MARYLAND 00091

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 00093 21

1. PLACE OF DEATH
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore — LENGTH OF STAY (In this place) 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS Bon Secours Hosp 63

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY A.A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold A.A. County
STREET ADDRESS (If rural, give location) Deep Creek

3. NAME OF DECEASED (Type or Print) (First) Estella (Middle) G. (Last) Baker
4. DATE OF DEATH (Month) Jan (Day) 7 (Year) 1953
5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Wd.
8. DATE OF BIRTH Jan 10, 1880
9. AGE last birthday 74 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Homemaker
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Constans Lefler
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Hospital Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

332 X
Immediate cause (a) Cerebral Thrombosis — 3 hrs.
Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Generalized Arterio Sclerosis — yrs.
260 X
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus & previous Cerebral Thrombosis 1 1/2 yrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 10, 1954, to Jan. 7, 1953, that I last saw the deceased alive on 1/7, 1953, and that death occurred at 9:00 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Marvin K Lawrence Md — ADDRESS Annapolis, Md — DATE SIGNED 1/10/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE Jan. 11 1953 — NAME OF CEMETERY OR CREMATORY Cathedral Cem. — LOCATION (City, town, or county) (State) Baltimore Md.

DATE REC'D BY LOCAL REG. 1-12-53 — REGISTRAR'S SIGNATURE J. Fred Bedwell

24. FUNERAL DIRECTOR Charles E. Delozier — ADDRESS Glen Burnie

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00094

00119 **CERTIFICATE OF DEATH** Reg. Dist. No. 23

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: plense write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North Linthicum
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7 Boulevard Place

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Linthicum X
STREET ADDRESS (If rural give location) 7 Boulevard Place

3. NAME OF DECEASED: (Type or Print) (First) EMMA (Middle) ELLEN (Last) BELL

4. DATE OF DEATH: (Month) January (Day) 17, (Year) 1955

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widowed
8. DATE OF BIRTH: June 21, 1877
9. AGE last birthday: 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Altoona, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Miles Rager
14. MOTHER'S MAIDEN NAME: Maggie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: North Linthicum
Howard Wiggington, 7 Boulevard Place

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 IMMEDIATE CAUSE	(A) Arteriosclerosis Coronary Artery	1 yr
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Arteriosclerosis Generalized	10 yrs ?
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Pulmonary Fibrosis Generalized	5 yrs ?

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1955, to Jan 17, 1955, that I last saw the deceased alive on Jan 16, 1955, and that death occurred at 6:00 P M, from the causes and on the date stated above.
SIGNATURE R. Allen Tossberg M.D. M. D. ADDRESS 2436 Washington Blvd-30 DATE SIGNED Jan 19 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY): burial
DATE THEREOF: 1/21/55
NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
LOCATION (City, town, or county) (State): Baltimore Maryland

DATE REC'D BY LOCAL REGISTRAR: 1-19-55
REGISTRAR'S SIGNATURE: A W Hedrick
24. FUNERAL DIRECTOR: Wm. Cook Inc.,
ADDRESS: 1217 St. Paul St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00095

00120 CERTIFICATE OF DEATH Reg. Dist. No. 28

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) First: William (Middle): N. (Last): Belt

4. DATE OF DEATH: (Month) 1 (Day) 6 (Year) 1955

5. SEX: Male | 6. COLOR OR RACE: Col. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W. | 8. DATE OF BIRTH: 1-14-1869 | 9. AGE last birthday: 85 yrs. | IF UNDER 1 YEAR: Months 11 Days 27 | IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Laborer | 10b. KIND OF BUSINESS OR INDUSTRY: Ft. Meade | 11. BIRTHPLACE (State or foreign country): Washington, D.C. | 12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: William Belt | 14. MOTHER'S MAIDEN NAME: Harriett Holman

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: William Belt - Gambrills, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Generalized Carcinomatosis DUE TO — Interval Between Onset And Death: 1 year

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

199.9

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1946 to Jan 10, 1955, that I last saw the deceased alive on Jan 6, 1955, and that death occurred at 12:45 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Edmund J Hamill M.D. | ADDRESS Gambrills MD | DATE SIGNED Jan 10, 1955

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 1-13-55 | NAME OF CEMETERY OR CREMATORY Mt. Tabor | LOCATION (City, town, or county) Chesterfield, Md. (State)

DATE REC'D BY LOCAL REGISTRAR Jan. 13, 1955 | REGISTRAR'S SIGNATURE K M Jones

24. FUNERAL DIRECTOR William Reese, II - 108 N. Washington St. Annapolis, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 19 1965
BUREAU V. S.

MARYLAND

STATE DEPARTMETT OF HEALTH

00121 **CERTIFICATE OF DEATH**

00096
Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Anne Arund'l — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum W. — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 409 Hawthorne Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY a.a.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum
STREET ADDRESS 409 Hawthorne Rd. W. (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Mabel (Middle) Frances (Last) Bly

4. DATE OF DEATH: (Month) 1 (Day) 21 (Year) 55

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct. 21, 1873

9. AGE last birthday: 81 yrs. — If under 1 year: Months. Days. — If under 24 hrs: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Felix R. Stocks

14. MOTHER'S MAIDEN NAME: Mary Falkner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: Mr. Felix Geschwilm-409 Hawthorne Rd. Linthicum

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) 260 Diabetes Mellitus.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio-Vascular disease (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from 5 ft 1955, to Jan 1955, that I last saw the deceased alive on 1-17, 1955, and that death occurred at 6 20 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) C. R. MacDonald M.D. ADDRESS Glen Burnie Md DATE SIGNED 1-21-55

23. BURIAL, CREMATION, REMOVAL (Specify) Cremation | DATE 1/24/55 | NAME OF CEMETERY OR CREMATORY Green Mount Crematory | LOCATION (City, town, or county) Baltimore, Md. (State)

DATE REC'D BY LOCAL REG. January 22 1955 | REGISTRAR'S SIGNATURE R. N | 24. FUNERAL DIRECTOR Wm. J. Dickner & Sons. ADDRESS Balto 17, Md

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00122

Reg. Dist. No. 000974

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie

LENGTH OF STAY (in this place): 5 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS 100 fourth ave. S. E.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland — COUNTY Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie

STREET ADDRESS (If rural, give location) 100 fourth ave. S. E.

3. NAME OF DECEASED: (First) WILLIAM (Middle) Henry (Last) BROMWELL

4. DATE OF DEATH: (Month) JANUARY (Day) 18 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 10, 1873

9. AGE last birthday: 81 yrs.

IF UNDER 1 YEAR: Months — Days

IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bricklayer (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Consolidated Engineering

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Bromwell

14. MOTHER'S MAIDEN NAME: Mary C. Raybine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT & ADDRESS: Mrs. Laura V. Bosley, 100 fourth ave. S. E. Glen Burnie, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause — 332X — (a) Cerebral Thrombosis — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b) Arteriosclerosis, general — DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH: 3 days

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/4, 19 49, to 1/18, 19 55, that I last saw the deceased alive on 1/17, 19 55, and that death occurred at 1:7 AM from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Bobby L. Jones M.D. ADDRESS 6 Central Ave. St. Glen Burnie DATE SIGNED 1/18/55

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF January 21, 1955 — NAME OF CEMETERY OR CREMATORY London Park Cemetery — LOCATION (City, town, or county) Baltimore (State) Maryland

DATE REC'D BY LOCAL REG. January 20, 1955 — REGISTRAR'S SIGNATURE L. J. D'Alba

24. FUNERAL DIRECTOR A. Pilkington — ADDRESS Glen Burnie, Md.

RECEIVED
JAN
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00092

Reg. Dist. No. 21 00098

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS USNH, Annapolis, Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis,
STREET ADDRESS (If rural give location) 1900 Fairfax Rd.

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) Wesley (Last) BROWN

4. DATE OF DEATH: (Month) JAN (Day) 20 (Year) 1955

5. SEX: M

6. COLOR OR RACE: CAU

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: 5-21-85

9. AGE last birthday 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): USN

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: OWEN BROWN

14. MOTHER'S MAIDEN NAME: Alice Reese

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213 28 4024

17. INFORMANT & ADDRESS: USNH Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X
IMMEDIATE CAUSE (A) Hemorrhage, cerebral # 331
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-6 ..., 1955, to 1-20 ..., 1955, that I last saw the deceased alive on 1-20 ..., 1955, and that death occurred at 10:15 P M, from the causes and on the date stated above.

SIGNATURE [signature] ADDRESS USNH, Annapolis, Md. DATE SIGNED 21 Jan 1955
M. D.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) DATE THEREOF 1-24-55 NAME OF CEMETERY OR CREMATORY Naval Academy Cem. LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REGISTRAR Jan. 23, 1955 REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR John M. Taylor & Son ADDRESS Annapolis Md

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00099

00123 - **CERTIFICATE OF DEATH** Reg. Dist. No. 23

1. PLACE OF DEATH:
COUNTY a. a. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Furnace Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY a. a.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights
STREET ADDRESS (If rural give location) Furnace Rd.

3. NAME OF DECEASED: (Type or Print) (First) HATTIE (Middle) B. (Last) CHILDRESS

4. DATE OF DEATH: (Month) Jan. (Day) 11, (Year) 19 55

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: Aug. 5, 1890

9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): W. Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Raine

14. MOTHER'S MAIDEN NAME: Virginia Lowe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17. INFORMANT & ADDRESS: Mr. Samuel A. Childress-Linthicum Hgts.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) DUE TO Generalized Abdominal Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 3 mo.

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: Oct 1954 — 19B. MAJOR FINDINGS OF OPERATION: Woman Hospital. Carcinoma Abdomen

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1, 1954, to Jan 11, 1955, that I last saw the deceased alive on Jan 6, 1955, and that death occurred at 9:30 PM, from the causes and on the date stated above.

SIGNATURE A Bradley Langhorthey M. D. ADDRESS 1264 Francis Ave DATE SIGNED Jan 12, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: 1/14/55 — NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Pk. — LOCATION (City, town, or county) (State): Elkridge, Md.

DATE REC'D BY LOCAL REGISTRAR: 1-13-55 — REGISTRAR'S SIGNATURE: a w Hearn — 24. FUNERAL DIRECTOR: Wm. J. Pickens & Sons — ADDRESS: Balto Md.

MARYLAND 00093

STATE DEPARTMENT OF HEALTH 00100

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — MARYLAND — LENGTH OF STAY (in this place) 10 — HOSPITAL OR INSTITUTION OR STREET ADDRESS 63 A. A. General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY A. A. — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — STREET ADDRESS (If rural, give location) 63 East Court 10 1

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) (Last) Ciccarone

4. DATE OF DEATH: (Month) 1 (Day) 14 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Apr. 18-1884

9. AGE last birthday: 70 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired U.S. Naval Civilian

10b. KIND OF BUSINESS OR INDUSTRY: Sailor

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Henry Ciccarone (2)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Pulmonary Edema acute.	12 hrs.
Antecedent cause(s)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Cirrhosis of Liver	1 month
	(c)	~~Cirrhosis~~	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Fractured Hip, left	7 wks.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-18-, 1954 to Jan 14, 1955, that I last saw the deceased alive on 1-14-, 1955, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) James A. Prentiss M.D. ADDRESS Annapolis, Md. DATE SIGNED 1-14-55

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE 1-17-55 | NAME OF CEMETERY OR CREMATORY St Mary's | LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Jan. 16, 1955 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR John M. Dayla Sons ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

(I)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 0014 1

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1936 Fairfax Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Anne Arundel
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 1936 Fairfax Road

3. NAME OF DECEASED: (Type or Print) (First) ORA (Middle) B. (Last) COX

4. DATE OF DEATH (Month) January (Day) 27 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. ~~SINGLE~~ ~~MARRIED~~, WIDOWED, ~~DIVORCED~~ (Specify):
8. DATE OF BIRTH: Unknown
9. AGE last birthday: 66 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Reg. Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (State or foreign country): Grotto Va
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: James W. Scable Jr (2)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Carbon monoxide poisoning — INTERVAL BETWEEN ONSET AND DEATH

~~DUE TO~~

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Second and third degree burns 98% of body surface — ~~DUE TO~~

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY home
21c. (City or town) Annapolis (County) Anne Arundel (State) Md.
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 1/27/55 12:50 P.M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☒
21f. HOW DID INJURY OCCUR? Burned during Fire in home

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED 1/28/55

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify):
DATE THEREOF 1-31-55
NAME OF CEMETERY OR CREMATORY Cedar Bluff
LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Jan. 30, 1955
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Green M. Taylor Sons ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

MARYLAND 00095

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 00102 24

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY A A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis 10
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. General 13

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md 10
STREET ADDRESS (If rural, give location) 318 Burnside Ave 1

3. NAME OF DECEASED (Type or Print): (First) Ethelbert (Middle) H. (Last) Daniels
4. DATE OF DEATH: (Month) Jan. (Day) 8 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	8-18-~~55~~1879	75 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lieutenant U.S.M.A.
10b. KIND OF BUSINESS OR INDUSTRY: Machinest
11. BIRTHPLACE (State or foreign country): ~~Virginia~~ Raleigh N. C.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Richard J. Daniels
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Thrombosis — 20 HRS

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis, generalized — unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Fibrosis — 10 YRS.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4 JAN., 1955., to 8 JAN, 1955., that I last saw the deceased alive on 8 JAN., 1955., and that death occurred at 2.25 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Edward Beck MD ADDRESS 41 Southgate Ave, Annapolis DATE SIGNED 1-8-55.

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	1-10-55	Nicarest Cem.	Annapolis	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
January 9, 1955	H. O'Donnell	John W. Sapp & Son	Annapolis Md.

RECEIVED
JAN 13 1955
BUREAU V.

00096

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00103 Reg. Dist. 21 No.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis

LENGTH OF STAY (in this place) 2 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS DCA Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE N.J. COUNTY Cape May

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Wildwood

STREET ADDRESS (If rural, give location) 142 W. RioGrande

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print)	4. DATE OF DEATH (Month) (Day) (Year)
MARY [illegible] DANIELS	JANUARY 4, 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	[illegible]	June 15, 1906	48 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
House wife	own home	New Jersey	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no — no	138-24-7042	Harold Daniels Jr., Son, 221 [illegible] St. Annapolis, [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Coronary disease	sudden
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)	
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
1-4-55 12:25a M.		Natural causes

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐ M. D. DATE SIGNED 1-4-55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	[illegible]	[illegible]	Wildwood, Cape May, New Jersey

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 4, 1955	[signature]	Ben I. Hopping and Son	Annapolis, Md.

MARYLAND 00097

STATE DEPARTMENT OF HEALTH 00104

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 1016 Van Buren Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis 10
STREET ADDRESS (If rural, give location): 1016 Van Buren Street 1

3. NAME OF DECEASED (Type or Print): (First) IV (Middle) LOUISE (Last) DAVIES

4. DATE OF DEATH: (Month) JANUARY (Day) 8 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 13, 1893

9. AGE last birthday: 61 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Birdsville, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Dove

14. MOTHER'S MAIDEN NAME: Laura Sherbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ---
(If year, give war or dates of service): ---

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mr James E. Davies, son - same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a). Carcinomatosis — Interval between onset and death: 6 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b). Carcinoma of Rectum — 1 yr.

(c).

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-5-, 1954, to 1-8-, 1955, that I last saw the deceased alive on 1-8-, 1955, and that death occurred at 9:45 a.m., from the causes and on the date stated above.

SIGNATURE: James A. Martin (Degree or title): MD ADDRESS: Annapolis, Md. DATE SIGNED: 1-10-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Jan. 10, 55

NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: January 10, 1955

REGISTRAR'S SIGNATURE: W. O'Donnell

24. FUNERAL DIRECTOR: Ben L. Hopping and Son ADDRESS: Annapolis, Md.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 13
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00124

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

00105

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Severna Park
LENGTH OF STAY (in this place): Few minutes
HOSPITAL OR INSTITUTION OR STREET ADDRESS: In an automobile Ritchie Highway

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Arnold X
STREET ADDRESS (If rural, give location): Joyce Lane /

3. NAME OF DECEASED (Type or Print): (First) Ellouise (Middle) (Last) Day

4. DATE OF DEATH: (Month) (Day) (Year): January 29 1955

5. SEX: F.

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: 11/9/54

9. AGE last birthday: yrs. 2 | If under 1 year: Months | Days 20 | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Anne Arundel County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Johnson

14. MOTHER'S MAIDEN NAME: Hazel Day

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT AND ADDRESS: Hazel Day (mother).

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 527.2 Acute pulmonary infection — INTERVAL BETWEEN ONSET AND DEATH: ?

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry X thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Eustace A. Faulkner M.D. | (Degree or title) Deputy Medical Examiner. | ADDRESS Glen Burnie, Md. | DATE SIGNED 1/29/55

BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb. 2/55	Int. Cedarhill	Arnold	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 31, 1955 (Feb 2, 1955)	L. L. D'Alba.	F. B. Johnson	Annapolis

VS. A15A

MARYLAND 00125

00106
STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 2

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
LENGTH OF STAY (In this place): 8yrs.8mos.24 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
STREET ADDRESS (If rural, give location): 1522 W. Lafayette Avenue

3. NAME OF DECEASED (Type or Print): Mary (First) M. (Middle) Dickerson (Last)

4. DATE OF DEATH: 1 (Month) 5 (Day) 1955 (Year)

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Separated

8. DATE OF BIRTH: June 1913

9. AGE last birthday: 41
If under 1 year: Months. — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John Askew

14. MOTHER'S MAIDEN NAME: Rebecca Hill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk.
(If year, give war or dates of service) — — —

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial damage — Interval between onset and death: Sudden death

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Deficiency without Psychosis — Known to us since 1946
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Metrorrhagie — One month

19a. DATE OF OPERATION: — — — —

19b. MAJOR FINDINGS OF OPERATION: — — — — — — — — — — — — — — — —

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): — — — —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: — — —

(CITY OR TOWN) (COUNTY) (STATE): — — — — — — — — — — — —

TIME OF INJURY (Month) (Day) (Year) (Hour): — — — — — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 1/21, 1948, to 1/5, 1955, that I last saw the deceased alive on 1/5, 1955, and that death occurred at 2:30 p. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): L. Benedict, M. D.
ADDRESS: Crownsville, Md.
DATE SIGNED: 1/5/55

23. BURIAL, CREMATION, REMOVAL (Specify) DATE: 1/8/1955
NAME OF CEMETERY OR CREMATORY: Mount Auburn
LOCATION (City, town, or county): Balto City (State): Md

DATE REC'D BY LOCAL REG.: January 8 1955
REGISTRAR'S SIGNATURE: R. W

24. FUNERAL DIRECTOR: Katie R. Williams
ADDRESS: 3224 N Chowan Ave

MARYLAND

00098

00107

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY: Anne Arundel; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis; LENGTH OF STAY (in this place): MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis, Md; STREET ADDRESS (If rural, give location): 223 Dewey Dr.

3. NAME OF DECEASED (Type or Print): (First) BABY (Middle) BOY (Last) EDELEN

4. DATE OF DEATH: (Month) JANUARY (Day) 10, (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: January 10, 55

9. AGE last birthday: -- yrs. If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. 5

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James E. Edelen

14. MOTHER'S MAIDEN NAME: Katherine Gallaway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ----- (If year, give war or dates of service): -----

16. SOCIAL SECURITY NO.: -----

17. INFORMANT AND ADDRESS: Mr. James E. Edelen- father- same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congenital Gromalia (multiple) — Interval Between Onset and Death: 5 min.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Atresia of Rectum, Bladder + Kidneys — 5 min.

(c)....

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes X No ☐

21. ACCIDENT (Specify) / SUICIDE / HOMICIDE | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-10-, 1955, to 1-10-, 1955, that I last saw the deceased alive on 1-10-, 1955, and that death occurred at 3:55 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) M.D. ADDRESS: Annapolis, Md. DATE SIGNED: 1-11-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Jan. 11, 55 | NAME OF CEMETERY OR CREMATORY: Riva Cemetery | LOCATION (City, town, or county) (State): Riva, Anne Arundel, Maryland

DATE REC'D BY LOCAL REG.: Jan. 11, 1955 | REGISTRAR'S SIGNATURE: [signature] | 24. FUNERAL DIRECTOR: Ben L. Hopkins and Son | ADDRESS: Annapolis, Md.

2015222394

RESERVED FOR BINDING

RECEIVED
JAN 12
BUREAU V. S.

10-53

MARYLAND

STATE DEPARTMETT OF HEALTH

00126 CERTIFICATE OF DEATH

00108 Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY A.A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Severn (Rural) | LENGTH OF STAY (in this place) 11 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn (Rural) X
STREET ADDRESS (If rural, give location) Quartee Field, Rd.

3. NAME OF DECEASED (Type or Print): (First) Thomas (Middle) Jefferson (Last) Gardner
4. DATE OF DEATH: (Month) 1 (Day) 23 (Year) 55
5. SEX M
6. COLOR OR RACE W
7. (MARRIED,) WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH 4/12/63
9. AGE last birthday 91 yrs. | If under 1 year: Months | Days | If under 24 hrs: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Thomas GARDNER
14. MOTHER'S MAIDEN NAME Edith M'Clain
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Mrs Barney Warfield, Severn, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: 6 week

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio Vascular Dis.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec ..., 19 54, to Jan ..., 19 55, that I last saw the deceased alive on 1-21 ..., 19 55, and that death occurred at 11 A ... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J.R. MacDonald M.D. ADDRESS Glen Burnie Md DATE SIGNED 1-23-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 1/26/55 | NAME OF CEMETERY OR CREMATORY Glen Haven | LOCATION (City, town, or county) (State) Glen Burnie, Md.

DATE REC'D BY LOCAL REG. January 24, 1955 | REGISTRAR'S SIGNATURE Mrs. Clara Hasley | 24. FUNERAL DIRECTOR Hopping & Kirkley | ADDRESS 421 Crain Highway SE Glen Burnie, Md.

by Direction

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09127

CERTIFICATE OF DEATH

001094

Reg. Dist. No. 6-55

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 6 Box 36	STREET ADDRESS (If rural, give location) Route 6 Box 36

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charlotte		Gellert.	Jan 15- 55 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
F	White	Widow	June 26-1870	84 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House-work (ret)	Own-Home	Poland	German

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Michael Orchekowski	Anna (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Jake Gellert - Box 376 Millersville-md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Thrombosis	2 weeks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Senility & Arteriosclerosis	1 Year
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	—	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—	—	—	—

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
—	—	—	m.		—

22. I hereby certify that I attended the deceased from Jan 1- 55 19 to Jan 15, 19 55, that I last saw the deceased alive on Jan 14-55, 19, and that death occurred at 7 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
[signature] M.D.	Pasadena Md.	Jan 15-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 19, 1955	Meadowridge	Washington Blvd. md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/17/55	L. J. DeAlba	R. V. Singleton - Glen Burnie, Md.	

1/17/55 L. J. DeAlba

RECEIVED
JAN 9

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00110

00128

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 6 days
10 HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City - 4
STREET ADDRESS (If rural give location) 1122 Whatcoat Street

3. NAME OF DECEASED: (Type or Print) (First) THOMAS (Middle) (Last) GRAY

4. DATE OF DEATH: (Month) 1 (Day) 11 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: 5/10/91
9. AGE last birthday 63 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unk.
(If Yes, give war or dates of service) WW I unk.
16. SOCIAL SECURITY NO. 213-09-9931 Unk.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

59?x

IMMEDIATE CAUSE (A) Uremia — Known to us for 6 days

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Chronic Glomerulonephritis — " — "

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertensive cardiovascular disease

19A. DATE OF OPERATION: - - - - -
19B. MAJOR FINDINGS OF OPERATION - - - - - - - - - - - - - - - - - -
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) - - - - - - - -
21C WHERE DID INJURY OCCUR? (City or town) (County) (State) - - - - - - - - - - -
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. - - - - -
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? - - - - - - - - - - -

22. I hereby certify that I attended the deceased from 1/5 ...., 19 55, to 1/11 ...., 19 55, that I last saw the deceased alive on 1/11, 19 55, and that death occurred at 11:10 PM, from the causes and on the date stated above.
SIGNATURE Guilford E. Naranjit M. D. ADDRESS Crownsville, Md. DATE SIGNED 1/11/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 1-14-55
NAME OF CEMETERY OR CREMATORY Balto Nat
LOCATION (City, town, or county) (State) md

DATE REC'D BY LOCAL REGISTRAR 1-13-55
REGISTRAR'S SIGNATURE H. W. Redmond
24. FUNERAL DIRECTOR George E. Nelson ADDRESS 1348 N. Calhoun St

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

MARYLAND 00099

STATE DEPARTMENT OF HEALTH 00111

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY ANNE ARUNDEL
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) A. APOLIS
LENGTH OF STAY (in this place) 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 West Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis 10
STREET ADDRESS (If rural, give location) 91 West Street 1

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GEORGE	ALBERT	GRINER	JANUARY	7,	19 55

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE Last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	May 17, 1877	77 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	State of Maryland	Baltimore, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John A. Griner	Sophie Bast

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
-----	-----	Mrs Sarah A. Griner -wife- same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

181X
Immediate cause (a) Uraemia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cancer of the Bladder

(c)

INTERVAL BETWEEN ONSET AND DEATH: Several days; about 2 1/2 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from April, 1954, to Jan. 7, 1955, that I last saw the deceased alive on Jan 7th, 1955, and that death occurred at 5-15 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J. Dewey Purvis	MD	40 Franklin St. Annapolis Md	1/10/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 11, 55	Cedar Fluff Cemetery	Annapolis, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
January 10, 1955	M. C. Brinsfield	Ben L. Hopping and Son	Annapolis, Md.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 13 1955
BUREAU V. S.

00109

01195
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY A. A. Co. | MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Annapolis | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD COUNTY A.A. Co
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) W. (Last) Gross

4. DATE OF DEATH (Month) JAN 8 (Day) (Year) 1955

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: 4-8-1875

9. AGE last birthday: 79 yrs. | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Welfare

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John W. Gross

14. MOTHER'S MAIDEN NAME: Louise DAVIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Hannah Gross - Annapolis, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) 927.9 Drowning — Interval Between Onset and Death: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) Spa Creek (County) AA Co (State) Md

21d. TIME OF INJURY (Month) 1 (Day) 5 (Year) 55 (Hour) 7 P.M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR? Fell Overboard

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE E. Rue Swift M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF 2-24-55 | NAME OF CEMETERY OR CREMATORY Brewer Hill | LOCATION (City, town, or county) Annapolis | (State) Md

DATE REC'D BY LOCAL REG. Feb 24, 1955 | REGISTRAR'S SIGNATURE H. C. Durand

24. FUNERAL DIRECTOR William Reese II | ADDRESS 108 Washington St Annapolis, Md

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00112

CERTIFICATE OF DEATH

00101 Reg. Dist. No. 21

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis
LENGTH OF STAY (in this place) 7 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 51 U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Texas COUNTY Jefferson
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Beaumont
STREET ADDRESS (If rural give location) 3765 Usan St.

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) (n) (Last) Guidry Jr.

4. DATE OF DEATH: (Month) January (Day) 15 (Year) 1955

5. SEX: M

6. COLOR OR RACE: N

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S

8. DATE OF BIRTH: June 8 1935

9. AGE last birthday 19 yrs. IF UNDER 1 YEAR Months 7 Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Texas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph (n) Guidry Sr.

14. MOTHER'S MAIDEN NAME: Vera (n) Mayes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) √Yes (If Yes, give war or dates of service) At. pres. time

16. SOCIAL SECURITY NO. 463-44-0507

17. INFORMANT & ADDRESS: U.S. Naval Hospital, Annapodis, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Endocarditis bacterial subacute # 430.0 — INTERVAL BETWEEN ONSET AND DEATH: 2½ mo.

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1, 1954, to Jan. 15, 1955, that I last saw the deceased alive on Jan. 15, 1955, and that death occurred at 1:10 PM, from the causes and on the date stated above.

SIGNATURE Robert K. MOXON LCDR MC USN M.D. ADDRESS U.S. Naval Hospital Annapolis, Md. DATE SIGNED 1-15-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal — DATE THEREOF 1-18-55 — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State) to Braumont, Texas

DATE REC'D BY LOCAL REGISTRAR Jan. 18, 1955 — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS Ben L. Hopping and Son Annapodis, Md

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00113

00129 CERTIFICATE OF DEATH Reg. Dist. No. 21

1. PLACE OF DEATH:
COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X GREEN HAVEN
LENGTH OF STAY (in this place) 5 MONTHS
HOSPITAL OR INSTITUTION OR STREET ADDRESS NO 13 TH STREET

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGHANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN REYNOLDS
STREET ADDRESS (If rural give location) 01X-2

3. NAME OF DECEASED: (Type or Print) (First) NORMAN (Middle) (Last) GUINN
4. DATE OF DEATH: (Month) JAN (Day) 26 (Year) 1955

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED
8. DATE OF BIRTH: Aug. 31, 1874
9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): R&T MINER
10b. KIND OF BUSINESS OR INDUSTRY: COAL MINE
11. BIRTHPLACE (State or foreign country): BARTON, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: —
14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-18-0932
17. INFORMANT & ADDRESS: BERTHA BURNS - DAUGHTER 13 TH ST. GREEN HAVEN MARYLAND

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
420.1
Immediate cause (a) CORONARY THROMBOSIS — Interval Between Onset And Death: 4 DAYS
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE — 10 YEARS
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from AUG. ,1954, to JAN 26, 1955, that I last saw the deceased alive on 1/24, 1955, and that death occurred at 2:30 A.M., from the causes and on the date stated above.
SIGNATURE J. Brady Smith (Degree or title) M.D. ADDRESS Riviera Beach, Md DATE SIGNED 1/26/55

23. BURIAL, CREMATION, REMOVAL (Specify) Removal DATE THEREOF 1/28/55 NAME OF CEMETERY OR CREMATORY Morrison Cemetery LOCATION (City, town, or county) (State) Reynolds, Maryland
DATE REC'D BY LOCAL REGISTRAR 1-27-55 REGISTRAR'S SIGNATURE A.W. Hebrick
24. FUNERAL DIRECTOR Wm. Cook Inc. ADDRESS 127 E. Pratt St.

M
I
MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00130 **CERTIFICATE OF DEATH** Reg. Dist. No. 00114

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Crownsville
LENGTH OF STAY (in this place) 6 mos. 15 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 1408 Retreat Street

3. NAME OF DECEASED: (Type or Print) (First) Elwood (Middle) (Last) Hall

4. DATE OF DEATH: (Month) 1 (Day) 21 (Year) 1955

5. SEX: Male | 6. COLOR OR RACE: Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single | 8. DATE OF BIRTH: 10-11-96 | 9. AGE last birthday: 58 yrs. | IF UNDER 1 YEAR: Months — Days — | IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10B. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

4 2 2.1
IMMEDIATE CAUSE (A) Chronic Myocarditis
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerosis DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senility

19A. DATE OF OPERATION: — — — —
19B. MAJOR FINDINGS OF OPERATION — — — — — — — — — — — — — — — —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — — — — — — — —
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) — — — — — — — — — — — — — — — —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? — — — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 7/6, 19 54 to 1/21, 19 55 that I last saw the deceased alive on 1/21, 19 55, and that death occurred at 6:05 A.M. from the causes and on the date stated above.
SIGNATURE C. E. Hardesty M.D. M. D.
[illegible] Crownsville, Md.
DATE SIGNED 1/21/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 1-25-55
NAME OF CEMETERY OR CREMATORY mt auburn
LOCATION (City, town, or county) (State) md

DATE REC'D BY LOCAL REGISTRAR 1-24-55
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR George E. Nelson
ADDRESS 1348 N. Calhoun st

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00102 **CERTIFICATE OF DEATH** Reg. Dist. No. 00115

1. PLACE OF DEATH:
COUNTY A.A. Co. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 ANNAPOLIS
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 13 AA General

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY AA Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
STREET ADDRESS (If rural give location) 915 Spa Rd.

3. NAME OF DECEASED: (Type or Print) (First) CELIA (Middle) (Last) HARVEY

4. DATE OF DEATH: (Month) 1 (Day) 26 (Year) 1965

5. SEX: F

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S

8. DATE OF BIRTH. 3-12-1910

9. AGE last birthday 44 yrs | IF UNDER 1 YEAR Months 10 Days 8 | IF UNDER 24 HRS Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic Housewife

10B. KIND OF BUSINESS OR INDUSTRY. Apt. House

11. BIRTHPLACE (State or foreign country): West River Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Harvey

14. MOTHER'S MAIDEN NAME: MARY PARKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-30-2612

17. INFORMANT & ADDRESS: Charles T. Kyler Annap. Md

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A)	Cardio Vascular Collapse	1 week.
ANTECEDENT CAUSE (5) DUE TO (B)	Cerebral injury.	1 week.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	Anoxia assoc. c Arteriosclerosis	1 week.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Pneumonia, Wound dehiscence	

19A. DATE OF OPERATION: Jan 10 '65

19B. MAJOR FINDINGS OF OPERATION: Myomectomy x 2

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 9, 1965 to Jan 26, 1965 that I last saw the deceased alive on Jan 20, 1965 and that death occurred at 5:20 M, from the causes and on the date stated above.

SIGNATURE Alan M. Chesney M.D. ADDRESS 69 Franklin DATE SIGNED 1/26/65

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 1-29-65 | NAME OF CEMETERY OR CREMATORY Brewer Hill | LOCATION (City, town, or county) (State) Annapolis Md.

DATE REC'D BY LOCAL REGISTRAR 1-27-65 | REGISTRAR'S SIGNATURE A. W. Hedrick | 24. FUNERAL DIRECTOR William Reese, Inc. ADDRESS 108 Northeast St.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

MARYLAND 00131

STATE DEPARTMETT OF HEALTH 00116

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY 02 Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Weems Creek, Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt 4 Box 872 Annapolis

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Weems Creek, Annapolis
STREET ADDRESS (If rural, give location) Rt 4 Box 872 Annapolis

3. NAME OF DECEASED (Type or Print) (First) RAYMOND (Middle) A. E. (Last) HIBBERD

4. DATE OF DEATH (Month) (Day) (Year) JANUARY 3, 1955 19

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Oct. 3, 1891

9. AGE last birthday 63 yrs. If under 1 year Months. Days. If under 24 hrs. Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman

10b. KIND OF BUSINESS OR INDUSTRY Lumber Company

11. BIRTHPLACE (State or foreign country) Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Hibberd

14. MOTHER'S MAIDEN NAME Mary Hinds

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) WW I

16. SOCIAL SECURITY NO. 214-05-0896

17. INFORMANT AND ADDRESS Raymond M Hibberd, Son, same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerotic cardiovascular disease — Interval between onset and death: 3yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/24, 1952 to 1/3, 1955, that I last saw the deceased alive on 1/3, 1955, and that death occurred at 7:40 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) s/ Bosworth MD ADDRESS Annapolis Md DATE SIGNED 1/5/55

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE January 5, 1955 NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery LOCATION (City, town, or county) (State) Annapolis, Maryland

DATE REC'D BY LOCAL REG. Jan. 5, 1955 REGISTRAR'S SIGNATURE s/ O. Council

24. FUNERAL DIRECTOR Ben L. Hopping and Son ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

BUREAU P
9 Mc

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00117

00132

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Fort George G. Meade
LENGTH OF STAY (in this place): 12 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 50 U. S. Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Odenton X
STREET ADDRESS (If rural give location): Betson Avenue

3. NAME OF DECEASED: (First) JOHN (Middle) — (Last) HOFFMAN

4. DATE OF DEATH: (Month) (Day) (Year) January 15 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: January 12, 1902

9. AGE last birthday: 53 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Driver

10B. KIND OF BUSINESS OR INDUSTRY: Trucking

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Hoffman

14. MOTHER'S MAIDEN NAME: Sophia Zimdel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes (If Yes, give war or dates of service): WW I WWII

16. SOCIAL SECURITY NO.: 213-28-4757

17. INFORMANT & ADDRESS: Mrs. Paul H. Martin, Meadedale, Odenton, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 9 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Hypertension DUE TO — unknown

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7 January 1955, to 15 January 1955 that I last saw the deceased alive on 15 Jan., 1955, and that death occurred at 0120 M, from the causes and on the date stated above.

SIGNATURE: Walter Galeanile — ADDRESS — M.D. — DATE SIGNED: 15 January 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: 18 Jan 55

NAME OF CEMETERY OR CREMATORY: Arlington National Cemetary

LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REGISTRAR: 17 January 1955

REGISTRAR'S SIGNATURE: E.J. BOMBOSH, CAPT. MSC

24. FUNERAL DIRECTOR — ADDRESS: Singleton Funeral Home, Glen Burnie, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00133

CERTIFICATE OF DEATH

00118

Reg. Dist. No. 2V

1. PLACE OF DEATH: District Training School
COUNTY Anne Arundel Co MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Laurel maryland
LENGTH OF STAY (In this place) 5-26-1950
HOSPITAL OR INSTITUTION OR STREET ADDRESS District Trainings School Laurel maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3Vp 1-4
STREET ADDRESS 216 East 20 Street (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Jarole (Middle) — (Last) Hogshead

4. DATE OF DEATH: (Month) 1 (Day) 20 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 8-13-06.

9. AGE last birthday: 48 yrs. IF UNDER 1 YEAR Months 4 Days 7 IF UNDER 24 HRS. Hours — Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clifton Hogshead

14. MOTHER'S MAIDEN NAME: Bermuda — unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: no

17. INFORMANT & ADDRESS: per recon of D.T.S. George Glass M.D.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

526X

Immediate cause (a) Bronchiectasis DUE TO — Interval Between Onset And Death: 2-3 weeks

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) arrested Tuberculosis of lungs DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. mental Deficiency

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED White at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from December 31, 19 54, to January 20, 19 55, that I last saw the deceased alive on 1-20, 19 55, and that death occurred at 7 05 P.M., from the causes and on the date stated above.

SIGNATURE George Glass (Degree or title) M.D. ADDRESS District Training School DATE SIGNED 1-20-55

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF 1-21-55 — NAME OF CEMETERY OR CREMATORY Hill Cemetery — LOCATION (City, town, or county) Anne Arundel Co (State) Md

DATE REC'D BY LOCAL REGISTRAR 1-21-55 — REGISTRAR'S SIGNATURE Edna Bailey — 24. FUNERAL DIRECTOR ADDRESS H T Talmadge M D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 7 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00134 **CERTIFICATE OF DEATH** Reg. Dist. No. 00119

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Crownsville
LENGTH OF STAY (in this place) 7 yrs. 6 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 405 Poppleton Street

3. NAME OF DECEASED: (Type or Print) (First) Fannie (Middle) Allsup (Last) Hooper

4. DATE OF DEATH. (Month) 1 (Day) 16 (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow

8. DATE OF BIRTH: 12/2/78

9. AGE last birthday 76 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Edward Giddings

14. MOTHER'S MAIDEN NAME: Susan Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.1 IMMEDIATE CAUSE	(A) Chronic Myocardial Disease	Known to us
ANTECEDENT CAUSE (S)	DUE TO	since 7/11/47
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Generalized Arteriosclerosis	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	General Paresis	

19A. DATE OF OPERATION: — — — — —

19B. MAJOR FINDINGS OF OPERATION — — — — — — — — — — — — — — — —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — — — — — —

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) — — — — — — — —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — — — M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? — — — — — — — —

22. I hereby certify that I attended the deceased from 1/21, 19 48 to 1/16, 19 55, that I last saw the deceased alive on 1/16, 19 55, and that death occurred at 3:50p.M, from the causes and on the date stated above.

SIGNATURE (L. Benedict) M. D. ADDRESS Crownsville, Md. DATE SIGNED 1/16/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 1/20/1955 | NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | LOCATION (City, town, or county) Balto. (State) Md.

DATE REC'D BY LOCAL REGISTRAR 1-18-55 | REGISTRAR'S SIGNATURE A W Hardwick

24. FUNERAL DIRECTOR Mrs Katie R Williams ADDRESS 322 N Schroeder St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00135

CERTIFICATE OF DEATH

00120

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A A County MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Bay Harbor
LENGTH OF STAY (in this place) 15 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS CO

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Rennn Beach x
STREET ADDRESS (If rural give location) R+6 Box 118 1

3. NAME OF DECEASED: (Type or Print) (First) Margaret (Middle) Elizabeth (Last) Hooper

4. DATE OF DEATH: (Month) Jan (Day) 24 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Jan 27-1877

9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR | Months | Days | IF UNDER 24 HRS. | Hours | Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): St Andrews West Ontario Canada

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Alexander MacDonald

14. MOTHER'S MAIDEN NAME: Mary Ann MacDonald

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Vincent A Hooper

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X

Immediate cause (a) Metastatic carcinoma of liver — Interval Between Onset And Death: 1 month

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Carcinoma of Colon — 1 month

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 20, 1953, to Jan. 24, 1955, that I last saw the deceased alive on Jan. 23, 1955, and that death occurred at 4 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) R. M. McLaughlin M.D. ADDRESS Pasadena Md. DATE SIGNED Jan. 24. 1955

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Jan 27 55 NAME OF CEMETERY OR CREMATORY St Johns Cemetery LOCATION (City, town, or county) (State) Richmond Hill New York NY

DATE REC'D BY LOCAL REGISTRAR January 24 1955 REGISTRAR'S SIGNATURE L. D'Alba

24. FUNERAL DIRECTOR Bernard G Fink ADDRESS Glen Burnie Md

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00136 Reg. Dist. No. 00121 28

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Crownsville
LENGTH OF STAY (in this place) 9yrs.10½mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Somerset
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Not ascertained 17X-2
STREET ADDRESS (If rural give location) " "

3. NAME OF DECEASED: (Type or Print) (First) Cornelius (Middle) (Last) Horsey
4. DATE OF DEATH: (Month) 1 (Day) 13 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Negro	Single	1913?	41? yrs.	—	—	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Never employed
10B. KIND OF BUSINESS OR INDUSTRY: — — —
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
No	No	No	Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
308.1 IMMEDIATE CAUSE	(A) Status Epilepticus	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO Idiopathic Convulsive Disorder Known	to us since 2/22/45
	(C)	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
— — — — — —	— — — — — — — — — — — — — — — —	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
	— — — — — —	— — — — — — — —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?
— — — — — M.		— — — — — — — —

22. I hereby certify that I attended the deceased from 1/21, 1948, to 1/13, 1955, that I last saw the deceased alive on 1/13, 1955, and that death occurred at 8:55 P.M. from the causes and on the date stated above.

SIGNATURE (L. Benedict) M. D. ADDRESS Crownsville, Md. DATE SIGNED 1/14/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 17th 55	Crownsville State Hospital	Crownsville Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
January 18, 1955	Catherine M. Joyce L. D. Asst.	Wm. J. A. Kerschig, W. Pendell St.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00122

00137

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-58

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Crownsville
LENGTH OF STAY (in this place) 1yr.10mos.6days
10 HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Springs 15X-2
STREET ADDRESS (If rural give location) None listed

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) (Last) Hough

4. DATE OF DEATH: (Month) 1 (Day) 25 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 7/18/93

9. AGE last birthday: 61 yrs
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10B. KIND OF BUSINESS OR INDUSTRY: — — — —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John Hough

14. MOTHER'S MAIDEN NAME: Annie Hough

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) — — —

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT & ADDRESS. Hospital Records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.0 IMMEDIATE CAUSE	(A) Hypertensive Cardiovascular Disease	2 years
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Arteriosclerotic Heart Disease	3 yrs
	DUE TO (C) general atherosclerosis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	right sided hemiplegia	2 yrs

19A. DATE OF OPERATION: — — — —

19B. MAJOR FINDINGS OF OPERATION — — — — — — — — — — — — — — — —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — — — — — —

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) — — — — — — — — — — — —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. — — — — —

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 1/5, 1955, to 1/25/, 19 55 that I last saw the deceased alive on 1/25, 19 55, and that death occurred at 12:25 P.M. from the causes and on the date stated above.

SIGNATURE Hildard Karl Kimmau ADDRESS Crownsville, Md. DATE SIGNED 1/25/55

M.D.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Jan 28, 55 | NAME OF CEMETERY OR CREMATORY Good Hope | LOCATION (City, town, or county) Colesville (State) Md

DATE REC'D BY LOCAL REGISTRAR 1-25-55 | REGISTRAR'S SIGNATURE H Moore

24. FUNERAL DIRECTOR Robert L. Spencer ADDRESS Rockville Md

MARYLAND STATE DEPARTMENT OF HEALTH

00103 **CERTIFICATE OF DEATH**

FOR MEDICAL EXAMINERS

00123

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS O'Bery Court

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS 8 Johnson Ct. (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Thomas (Middle) Jerome (Last) Isaacs

4. DATE OF DEATH: (Month) JAN (Day) 27 (Year) 1955

5. SEX: Male — 6. COLOR OR RACE: Colored — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S — 8. DATE OF BIRTH: 1-29-1935 — 9. AGE last birthday: 19 yrs. — If under 1 year: Months 11 / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer — 10b. KIND OF BUSINESS OR INDUSTRY: Annapolis City — 11. BIRTHPLACE (State or foreign country): Annapolis Md. — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sellman Isaacs — 14. MOTHER'S MAIDEN NAME: Ola Parker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No — 16. SOCIAL SECURITY NO. — 17. INFORMANT: Sellman Isaacs - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Crushing Injury to chest — Interval Between Onset and Death: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Asphyxia

(c)

II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. — PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) Street — (CITY OR TOWN) ANNAPOLIS — (COUNTY) ANNE ARUNDEL — (STATE) MD

TIME OF INJURY (Month) (Day) (Year) (Hour) 1 24 55 P m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY occur? Came in - yr Tenner Line

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE [signature] (Degree or title) MD — ADDRESS Annapolis Md — DATE SIGNED 1/27/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1-28-55 — NAME OF CEMETERY OR CREMATORY Annapolis Memorial Park — LOCATION (City, town, or county) (State) Annapolis Md.

DATE REC'D BY LOCAL REG. Jan. 28, 1955 — REGISTRAR'S SIGNATURE [signature] — 24. FUNERAL DIRECTOR — ADDRESS Dickinson Bros. Inc. 11-13 W. Washington St. Annapolis, Md.

RECEIVED
JAN 31 1955
BUREAU V. S.

MARYLAND 00138

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

00124

Reg. Dist. No. 25

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville, Md.
LENGTH OF STAY (in this place): 8 mo. 14 days
10 HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Springs, Md.
STREET ADDRESS (If rural, give location): Route 1, Brookville Road

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Calvin	Leroy	James		1	14	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Negro	Single	March 1, 1945	9 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ———
10b. KIND OF BUSINESS OR INDUSTRY: ———
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Leroy James
14. MOTHER'S MAIDEN NAME: Margaret Henderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: Hospital Records, Crownsville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

21 7 X

Immediate cause (a) Hydrocephalus — known to us since 4/30/1954

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ———

(c) Post Pertussis Encephalitis — known to us since 4/30/54

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ———
19b. MAJOR FINDINGS OF OPERATION: ———
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ———
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: ———
(CITY OR TOWN) (COUNTY) (STATE): ———

TIME OF INJURY (Month) (Day) (Year) (Hour): ——— m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?: ———

22. I hereby certify that I attended the deceased from 4/30, 1954, to 1/14, 1955 that I last saw the deceased alive on 1/14, 1955, and that death occurred at 8:25 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Stanley C. Sargent MD
ADDRESS: Crownsville, Md.
DATE SIGNED: 1/14/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 1-17-55
NAME OF CEMETERY OR CREMATORY: Linden
LOCATION (City, town, or county) (State): Gaithersburg, Md.

DATE REC'D BY LOCAL REG. 1-18-55
REGISTRAR'S SIGNATURE: [signature]
24. FUNERAL DIRECTOR / ADDRESS: [illegible]

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00125

00139

CERTIFICATE OF DEATH

Reg. Dist. No. 23

Item 2, Film G176 1-25-55 et

1. PLACE OF DEATH: COUNTY ARUNDEL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X GLEN BURNIE
LENGTH OF STAY (in this place) 32 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS PLAZA MANOR NURSING Home Route 2 Box 376A

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Baltimore
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix 09X-2
STREET ADDRESS (If rural give location) Route # 1

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) (Last) JARRETT

4. DATE OF DEATH: (Month) Jan (Day) 17 (Year) 1955

5. SEX: M

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Mar

8. DATE OF BIRTH. March 1900

9. AGE last birthday 54 yrs. IF UNDER 1 YEAR, Months Days IF UNDER 24 HRS., Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Jarrett

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Nettie Jarrett 1303 N. Bruce St

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

159X
IMMEDIATE CAUSE (A) Carcinomatosis general — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Carcinoma of gastrointe-
DUE TO (C) tinal tract

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 15, 1955, to Jan 17, 1955, that I last saw the deceased alive on Jan 15, 1955, and that death occurred at 9:00 P M, from the causes and on the date stated above.
SIGNATURE Joseph Taler M. D. ADDRESS 102 Balto-Annap. Blvd. Glen Burnie DATE SIGNED 1/17/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 1-21-55
NAME OF CEMETERY OR CREMATORY Mt Auburn
LOCATION (City, town, or county) Md (State)

DATE REC'D BY LOCAL REGISTRAR 1-19-55
REGISTRAR'S SIGNATURE A W Hedrick

24. FUNERAL DIRECTOR George G. Olson ADDRESS 1348 N Calhoun St

MARYLAND 00104

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

00126 Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Melrose Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Melrose Street

3. NAME OF DECEASED (Type or Print): (First) Walter (Middle) John (Last) Jerner

4. DATE OF DEATH: (Month) January (Day) 26 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 23,1914

9. AGE last birthday: 40 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY: Commerical Bldg.

11. BIRTHPLACE (State or foreign country): Chicago, Ill

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Jerner

14. MOTHER'S MAIDEN NAME: Judith Lofgren

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) 1-15-34 to 1-13-38

16. SOCIAL SECURITY NO. 212-14-8653

17. INFORMANT AND ADDRESS: Mrs. Frances Joann Jerner- wife- same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Myocardial Infarction, acute

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Thrombosis

(c)

INTERVAL BETWEEN ONSET AND DEATH: (a) 1 hr. (b) 1 hr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-26-, 1955 to 1-26-, 1955, that I last saw the deceased alive on 1-26-1955, and that death occurred at 9:05 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) James R. Martin M.D. ADDRESS Annapolis, Md. DATE SIGNED 1-28-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Jan. 29,55

NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Cemet.

LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: Jan. 28, 1955

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: Ben L. Hopping and Son ADDRESS: Annapolis, Md.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

(2)

MARYLAND STATE DEPARTMENT OF HEALTH

00127

09140

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pasadena
LENGTH OF STAY (in this place): 20 y.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Rock Creek

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Same — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Same
STREET ADDRESS (If rural, give location): Same

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Edward (Last) Jessop

4. DATE OF DEATH: (Month) Jan. (Day) 24 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: 12/19/74

9. AGE last birthday: 80 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired grave digger.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Reistertown, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dominic Brown Jessop

14. MOTHER'S MAIDEN NAME: Susan R. Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: George Edward Jessop (nephew)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General arteriosclerosis. — Interval between onset and death: ?

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. WAS FINAL CAUSE WAS PRIMARY OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Rudolph H. Faulkner M.D. (Degree or title): Deputy Medical Examiner ADDRESS: Glen Burnie, Md. DATE SIGNED: 1/24/55

FINAL DISPOSITION (Burial, Cremation, or Removal, Specify): BURIAL

DATE THEREOF: 29 JAN '55

NAME OF CEMETERY OR CREMATORY: REISTERSTOWN - M.E.

LOCATION (City, town, or county) (State): REISTERSTOWN - MD

DATE REC'D BY LOCAL REG.: 1-27-55

REGISTRAR'S SIGNATURE: G. L. Hedrick

24. FUNERAL DIRECTOR: Harry H. Witzke - Butler, Md. ADDRESS:

US AFA

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00128

00141 **CERTIFICATE OF DEATH** Reg. Dist. No. ....

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Crownsville
LENGTH OF STAY (in this place) 14 yrs. 11mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3Y 1.4
STREET ADDRESS (If rural give location) 1128 W. Lafayette Street

3. NAME OF DECEASED: (Type or Print) (First) Ula (Middle) (Last) Jones

4. DATE OF DEATH: (Month) 1 (Day) 17 (Year) 1955

5. SEX: Female | 6. COLOR OR RACE: Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow | 8. DATE OF BIRTH: 66? | 9. AGE last birthday 1888? yrs. | IF UNDER 1 YEAR Months — Days — | IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10B. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Henry Goodrich

14. MOTHER'S MAIDEN NAME: Alice Holman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4"

IMMEDIATE CAUSE (A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: At least 5 yrs.

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized Arteriosclerosis DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: - - - - - - | 19B. MAJOR FINDINGS OF OPERATION - - - - - - - - - - - - - - - - | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY - - - - - - - - | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) - - - - - - -

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY - - - - - - - - M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR? - - - - - -

22. I hereby certify that I attended the deceased from 10/26, 1952, to 1/17, 1955 that I last saw the deceased alive on 1/17, 1955., and that death occurred at 11:30a.M, from the causes and on the date stated above.

SIGNATURE Stephen E. Kramer M. D. ADDRESS Crownsville, Md. DATE SIGNED 1/17/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 1/21/55 | NAME OF CEMETERY OR CREMATORY arbutus | LOCATION (City, town or county) (State) Balto, Md

DATE REC'D BY LOCAL REGISTRAR 1-20-55 | REGISTRAR'S SIGNATURE A. R. Hedrick M.D. | 24. FUNERAL DIRECTOR H. C. Wilson per Sam Anderson | ADDRESS

MARYLAND 00142

00129

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH
COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mayo
LENGTH OF STAY (in this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mayo
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Roland (Middle) Fletcher (Last) Lee Sr.
4. DATE OF DEATH (Month) 1 (Day) 16 (Year) 1955
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower
8. DATE OF BIRTH 4-17-1879
9. AGE last birthday 75 yrs. If under 1 year Months. Days. If under 24 hrs. Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter
10b. KIND OF BUSINESS OR INDUSTRY Boat-House
11. BIRTHPLACE (State or foreign country) Mayo A A Co Md
12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Joseph A. Lee
14. MOTHER'S MAIDEN NAME Rebecca M. Purdy
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Thomas E. Lee (2)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: 1 wk.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Heart Disease — 2 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 15, 1947, to 1-16-, 1955, that I last saw the deceased alive on 1-16-55, and that death occurred at 7.30 P m., from the causes and on the date stated above.

SIGNATURE John A. Martin (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED 1-17-55

23. BURIAL, CREMATION, REMOVAL (Specify) DATE 1-19-55 NAME OF CEMETERY OR CREMATORY Mayo Memorial LOCATION (City, town, or county) Mayo (State) Md

DATE REC'D BY LOCAL REG. Jan. 18, 1955 REGISTRAR'S SIGNATURE Edward Gollinson

24. FUNERAL DIRECTOR John M. Taylor & Sons ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

MARYLAND 00105

00130
STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY A. A. | MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (in this place) 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. G. General 62

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis 10
STREET ADDRESS (If rural, give location) 1032 West St. 1

3. NAME OF DECEASED (Type or Print): (First) Irene (Middle) (Last) Lewis
4. DATE OF DEATH: (Month) 1 (Day) 16 (Year) 1955

5. SEX F | 6. COLOR OR RACE W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. Widow | 8. DATE OF BIRTH Sept 13 1874 | 9. AGE last birthday 80 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Mayo Md. | 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Samuel J. Carr | 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS Leslie Brashears (2)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause (a) Arteriosclerotic cardiovascular disease	10 yrs
Antecedent cause(s)	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cystopyelitis	3 wks.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... , 19 , to ..... , 19 , that I last saw the deceased alive on 1/16 , 1955 , and that death occurred at 8:45 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. Brownell M.D. | ADDRESS Annapolis Md. | DATE SIGNED 1/17/55

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE 1-18-55 | NAME OF CEMETERY OR CREMATORY Mayo Memorial | LOCATION (City, town, or county) Mayo | (State) Md

DATE REC'D BY LOCAL REG. Jan. 18, 1955 | REGISTRAR'S SIGNATURE J. Brownell | 24. FUNERAL DIRECTOR John M. Leuthauser | ADDRESS Annapolis Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00143 CERTIFICATE OF DEATH

Reg. Dist. No. 00134 V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LAUREL
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS District TRAINING School LAUREL, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LAUREL
STREET ADDRESS (If rural give location) District Training School

3. NAME OF DECEASED: (Type or Print) (First) RAYMOND (Middle) (Last) LOHMAN

4. DATE OF DEATH: (Month) JAN. (Day) 16 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: Feb 19, 1916

9. AGE last birthday: 38 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): WASHINGTON, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LLOYD F. LOHMAN

14. MOTHER'S MAIDEN NAME: ELSIE HINES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT & ADDRESS: District Training School's Record File

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 416X (a) CONGESTIVE HEART FAILURE — Interval Between Onset And Death: 10 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Rheumatic Heart Disease

DUE TO

(c) Hypostatic Pneumonia

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: (1) MENTAL DEFICIENCY - FAMILIAL VARICOSITIES AND VARICOSE ULCER

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JAN. 6, 1955, to JAN. 16, 1955, that I last saw the deceased alive on JAN. 16, 1955, and that death occurred at 5:25 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Margaret Wong Mole M.D. M. D. District Training School Laurel Md Jan. 16 1955

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Jan 17-55 — NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery — LOCATION (City, town, or county) Bladensburg (State) Md

DATE REC'D BY LOCAL REGISTRAR Jan 16-55 — REGISTRAR'S SIGNATURE Clara Hasbrook

24. FUNERAL DIRECTOR W. O. Chambers, Wellington ADDRESS

RECEIVED
FEB 7 1955
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00132

00106 CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
02 COUNTY Anne Arundel MARYLAND
10 CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR 20 STREET ADDRESS Bay Ridge Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A. A.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 10
STREET ADDRESS (If rural give location) Bay Ridge Ave. 1

3. NAME OF DECEASED: (Type or Print) (First) Baby (Middle) (Last) McHenry

4. DATE OF DEATH: (Month) 1 (Day) 3 (Year) 1955

5. SEX: Male | 6. COLOR OR RACE: Col. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S. | 8. DATE OF BIRTH: 1-2-55 | 9. AGE last birthday yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): Annapolis, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Reginald McHenry | 14. MOTHER'S MAIDEN NAME: Evoine Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) | 16 SOCIAL SECURITY NO | 17. INFORMANT & ADDRESS: Reginald McHenry

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Congenital Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/2, 1955, to 1/3, 1955, that I last saw the deceased alive on 1/3, 1955, and that death occurred at 6:30 A M, from the causes and on the date stated above.

SIGNATURE Glendine A. Johnson M. D. ADDRESS 37 Calvert Street Annapolis, Md. DATE SIGNED 1/3/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 1-5-55 | NAME OF CEMETERY OR CREMATORY Brewer Hill | LOCATION (City, town or county) (State) Annapolis, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 4, 1955 | REGISTRAR'S SIGNATURE M. O. Brewer

24. FUNERAL DIRECTOR ADDRESS William Reese, 2108 Washington St. Anna. Md.

10152243333

JAN 6
BUREAU V

00133

00144

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne-Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills — LENGTH OF STAY (In this place) all life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Evergreen Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Same W. Va., COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same
STREET ADDRESS (If rural, give location) Same (See birth cert.)

3. NAME OF DECEASED (Type or Print): (First) ORBIE — (Middle) DOUGLAS — (Last) McVey.
4. DATE OF DEATH: (Month) January (Day) 4 (Year) 1955

5. SEX: M.
6. COLOR OR RACE: Colored.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 11/11/54
9. AGE last birthday: yrs. 7 — If under 1 year: Months — Days 23 — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Gambrills, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clermont McVey
14. MOTHER'S MAIDEN NAME: Josephine Lillian Desnazor.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: Mrs. C. McVey (mother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 14 hrs.

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH:
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22 *I certify that I took charge of the remains described above, held an Autopsy ___, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☒ accident ___, suicide ___, homicide ___, undetermined ___.*

SIGNATURE (Degree or title): Andrew H. Fowler M.D. — ADDRESS: Medical Examiner, Glen Burnie, Md. — DATE SIGNED: 1/5/55

AT CREMATION, BURIAL, or other (Specify): Burial — DATE THEREOF: Jan 7, 1955 — NAME OF CEMETERY OR CREMATORY: Brown Hill — LOCATION (City, town, or county) (State): Annapolis, Md.

DATE REC'D BY LOCAL REG.: Jan. 8, 1955 — REGISTRAR'S SIGNATURE: K. Magee — 21. FUNERAL DIRECTOR: J.B. Johnson — ADDRESS: Annapolis, Md.

10 40X4275405

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

00134

MARYLAND — STATE DEPARTMETT OF HEALTH

00107

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY A.A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
LENGTH OF STAY (in this place) 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 ADMIRAL DRIVE

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MD. COUNTY A.A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS 10
STREET ADDRESS (If rural, give location) ADMIRAL DRIVE 1

3. NAME OF DECEASED (Type or Print): (First) IDA (Middle) BELLE (Last) MORELAND

4. DATE OF DEATH: (Month) 1 (Day) 28 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 1/29/1879

9. AGE last birthday: 75 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME

10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: JOHN W. FAUST

14. MOTHER'S MAIDEN NAME: HARRIETT L. BRADY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: HARRY F. MORELAND #2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

53 GK

Immediate cause (a) arteriosclerotic cardiovascular disease — Interval Between Onset and Death: 10 yr

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)... (c) chronic bronchitis — 15 yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 19 49, to Jan 28, 19 55, that I last saw the deceased alive on Jan 28, 1955, and that death occurred at 2:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) R Bozorth M.D — ADDRESS Annapolis Md — DATE SIGNED 1/30/55

23. BURIAL, CREMATION, ~~REMOVAL~~ (Specify) — DATE 2/1/55 — NAME OF CEMETERY OR CREMATORY Mt. Zion — LOCATION (City, town, or county) Mt. Zion — (State) Md.

DATE REC'D BY LOCAL REG. Jan. 31, 1955 — REGISTRAR'S SIGNATURE H. E. Council

24. FUNERAL DIRECTOR John M. Taylor & Sons — ADDRESS Annapolis

BUREAU V. &

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00135

00145 # CERTIFICATE OF DEATH Reg. Dist. No. ..

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

1. PLACE OF DEATH. COUNTY A. A. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tracys
LENGTH OF STAY (In this place) 52 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Md COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Tracys
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) William (Middle) Henry (Last) Mullen
4. DATE OF DEATH: (Month) Jan (Day) 16 (Year) 1955
5. SEX: M
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widower
8. DATE OF BIRTH: March 27, 1867
9. AGE last birthday 87 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10B. KIND OF BUSINESS OR INDUSTRY: Tobacco
11. BIRTHPLACE (State or foreign country): Natwell
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Thomas F. Mullen
14. MOTHER'S MAIDEN NAME: Priscilla Wells
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT & ADDRESS: John W. Mullen, Tracys Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0
IMMEDIATE CAUSE (A) Arteriosclerosis generalized & severe — INTERVAL BETWEEN ONSET AND DEATH 1½ yrs

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec ., 1954, to 16 Jan, 1955, that I last saw the deceased alive on 16 Jan ., 1955, and that death occurred at 4 P. M, from the causes and on the date stated above.
SIGNATURE M. D ADDRESS DATE SIGNED 17 Jan 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Jan 19, 1955 — NAME OF CEMETERY OR CREMATORY Carters — LOCATION (City, town, or county) (State) Friendship, A.A. Md

DATE REC'D BY LOCAL REGISTRAR 1-17-55 — REGISTRAR'S SIGNATURE Edw Wisner Wilkins — 24. FUNERAL DIRECTOR T A Hardesty & Son — ADDRESS Galesville Md

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00146

Reg. Dist. No. 00136 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Pasadena A.A. CO. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena
LENGTH OF STAY (in this place) 4years
HOSPITAL OR INSTITUTION OR STREET ADDRESS North Shore, Pasadena, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena
STREET ADDRESS (If rural give location) North Shore, Eagle Hill

3. NAME OF DECEASED: (First) Stanley (Middle) (Last) Muzdakis (Muzdeikas)

4. DATE OF DEATH: (Month) Jan. (Day) 7 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 15, 1878
9. AGE Last birthday: 76 yrs. IF UNDER 1 YEAR: Months 2 Days 22 IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Tailor
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Lithuania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service) ****
16. SOCIAL SECURITY No.: ?
17. INFORMANT & ADDRESS: Esther Rutkauskis North Shore Pasadena Md.

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause 4437	(a) Cerebral hemorrhage	1 Hours
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Hypertension	2 years
	DUE TO (c) Arteriosclerotic Cardio-vascular disease	2 years
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	none	

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 19, 1953, to Jan. 7, 1955, that I last saw the deceased alive on Jan. 7, 1955, and that death occurred at ....., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
C. M. McLaughlin M.D. Pasadena. Md. Jan. 7. 1955

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1/12/55
NAME OF CEMETERY OR CREMATORY Most Holy Redeemer
LOCATION (City, town, or county) (State) Belair Rd. Maryland

DATE REC'D BY LOCAL REGISTRAR 1/11/55
REGISTRAR'S SIGNATURE O W Hedrick
24. FUNERAL DIRECTOR Esther W Rutkauskas
ADDRESS 103 McHenry St Balto 30

MARYLAND

00147

00137

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Davidsonville
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 08 Davidsonville P.O.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural , Davidsonville
STREET ADDRESS (If rural, give location): X 1

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) A (Last) OWENS

4. DATE OF DEATH (Month) (Day) (Year): JANUARY 15, 1955 19

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: March 27, 1865

9. AGE last birthday: 89 yrs. — If under 1 year: Months. Days. — If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own farm

11. BIRTHPLACE (State or foreign country): Anne Arundel County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ~~Unknown~~ George H. Owens

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Ellen Atwell. (ATWELL)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mrs Thomas Dawson- Daughter- same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a)..... myocardial failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)..... generalized arteriosclerosis + coronary artery disease

(c)...

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not White At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from..... ....., 19 45, to Jan 15, 1955, that I last saw the deceased alive on Jan 15, 1955, and that death occurred at 9 P.M., from the causes and on the date stated above.

SIGNATURE: Emily H. Wilson (Degree or title) M.D. ADDRESS: Latrobe, Md. DATE SIGNED: 1-16-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 1-18-55 | NAME OF CEMETERY OR CREMATORY: Hope Chapel Cemetery | LOCATION (City, town, or county) (State): Edgewater, Anne Arundel, Maryland

DATE REC'D BY LOCAL REG.: Jan. 17, 1955 | REGISTRAR'S SIGNATURE: Carrie J. Smith. Reed Jan 19—

24. FUNERAL DIRECTOR: Ben L. Hopping and Son ADDRESS: Annapolis, Md.

RECEIVED
FEB 1 1955
BUREAU V. S.

MARYLAND

00108

00138

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY A A
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
LENGTH OF STAY (in this place) 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. General Hospt.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY A A
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 10
STREET ADDRESS (If rural, give location) 100 Archwood Ave

3. NAME OF DECEASED (Type or Print) Fannie (First) A. (Middle) Porter (Last)

4. DATE OF DEATH (Month) 1 (Day) 10 (Year) 1955

5. SEX F

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow

8. DATE OF BIRTH 2-25-1861

9. AGE last birthday 93 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Salisbury Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Clayton Phippin

14. MOTHER'S MAIDEN NAME Susan Hasting

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Mrs Reese Wimbrow (2)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) arteriosclerotic cardiovascular disease. 80 yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 12, 1942 to Jan 10, 1955, that I last saw the deceased alive on Jan 10, 1955, and that death occurred at 1:15 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J Bowers MD ADDRESS Annapolis Md DATE SIGNED 1/12/55

23. BURIAL, CREMATION, REMOVAL (Specify) DATE 1-12-55 NAME OF CEMETERY OR CREMATORY Parson Cemt LOCATION (City, town, or county) Salisbury (State) Md

DATE REC'D BY LOCAL REG. Jan. 12, 1955 REGISTRAR'S SIGNATURE H. O. Brown

24. FUNERAL DIRECTOR Jerome F. Taylor Sons ADDRESS Annapolis Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00139

00148 CERTIFICATE OF DEATH Reg. Dist. No. 8

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Crownsville
LENGTH OF STAY (in this place) 2 yrs. 23 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Caroline
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg 05X-2
STREET ADDRESS (If rural give location) None listed

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) (Last) Ricketts
4. DATE OF DEATH: (Month) 1 (Day) 23 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Negro	Widowed	1874?	80? yrs.	—	—	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farming	Maryland	U. S.

13. FATHER'S NAME: Borderick Ricketts
14. MOTHER'S MAIDEN NAME: Ann Ricketts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16 SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
Unk. Unk.	Unk.	Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

434.3
IMMEDIATE CAUSE (A) Hypostatic pneumonia
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Cardiac Disease

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
— — —	— — — — — — — — — — — — — — — —	YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
	— — — — —	— — — — — — —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?
— — — — — — — M.		— — — — — — —

22. I hereby certify that I attended the deceased from 12/31, 1952, to 1/23, 1955, that I last saw the deceased alive on 1/23, 1955, and that death occurred at 7:20 AM. from the causes and on the date stated above.

SIGNATURE (L. Benedict, M.D.) ADDRESS Crownsville, Md. DATE SIGNED 1/23/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	1/26/55	Bethel Cemetery	Federalsbury, Maryland

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
1-24-55		J. J. Frampton & Son, Federalsburg, Md.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00140

00149 # CERTIFICATE OF DEATH Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
X CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Avalon Shores
LENGTH OF STAY (in this place) 5 yrs
00 HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Avalon Shores
STREET ADDRESS (If rural give location) 1605 Leech Drive

3. NAME OF DECEASED: (Type or Print) (First) Annie (Middle) A. (Last) Robinson
4. DATE OF DEATH: (Month) Jan (Day) 9 (Year) 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Dec 20 1874	80 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Bristol, A.A Co Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph B. Ward.
14. MOTHER'S MAIDEN NAME: Rebecca Hutchinson Avalon Shores Md

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Mrs Annie Hall 1605 Leech Drive Avalon Shores Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause	(a) Consolidation of lungs	10 days.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Carcinoma of left breast with	10 years
	DUE TO (c) Metastasis to lungs.	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6 Dec., 19 54, to 9 Jan., 19 55, that I last saw the deceased alive on 9 Jan., 19 55, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Franklin D. Hendricks		Shadyside, Maryland	10 Jan 55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 11, 1955	Central Methodist Am	Baltimore, Md

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 11, 1955	Elsie Hurt Williams	William H. Hutchins,	Owings Md.

00109

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 00141

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place) 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS 63 A. A. Gen. Hospt.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY A A.
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural Annapolis
STREET ADDRESS (If rural, give location) X /

3. NAME OF DECEASED: (Type or Print) (First) Gilbert (Middle) Lee (Last) Sakers

4. DATE OF DEATH (Month) 1 (Day) 28 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify):

8. DATE OF BIRTH: 1-30-1906

9. AGE last birthday: 48 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Supt. Trouble Dept.

10b. KIND OF BUSINESS OR INDUSTRY: Gas + Elect. Co.

11. BIRTHPLACE (State or foreign country): Laurel Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Theodore Sakers

14. MOTHER'S MAIDEN NAME: Susan C. Harrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Theodore Lee Sakers Riva Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Coronary disease DUE TO — Interval Between Onset and Death: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Kenneth

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
M. D. ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 1/24/55

23. BURIAL, CREMATION, ~~REMOVAL~~ (Specify): DATE THEREOF 1-30-55 NAME OF CEMETERY OR CREMATORY Ivory Hill Cemetery LOCATION (City, town, or county) Laurel Prince Geo (State) Md.

DATE REC'D BY LOCAL REG. Jan. 30, 1955

REGISTRAR'S SIGNATURE H. C. Pond

24. FUNERAL DIRECTOR John M. Taylor & Son ADDRESS Annapolis Md

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00142

00158 CERTIFICATE OF DEATH Reg. Dist. No. 27

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Fort George G. Meade
LENGTH OF STAY (in this place) 8 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S.Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Pennsylvania COUNTY McKean
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Smithport 75 X -
STREET ADDRESS (If rural give location) 514 Marvin St.

3. NAME OF DECEASED: (Type or Print) (First) Michael (Middle) Francis (Last) Sample

4. DATE OF DEATH: (Month) (Day) (Year) Jan 30 1955

5. SEX: Male

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Singel

8. DATE OF BIRTH: 26 Jan 55

9. AGE last birthday yrs. IF UNDER 1 YEAR Months Days 4 IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Edward Sample

14. MOTHER'S MAIDEN NAME: Florence Catherine Gottardi

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) -

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Mother, Apt 5A, Glenwood Rd., Balto., Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 77 to X (A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 26 Jan, 19 55 to 30 Jan, 19 55 that I last saw the deceased alive on 30 Jan, 1955, and that death occurred at 0004 M, from the causes and on the date stated above.

SIGNATURE J. S. ARDINGER, MD — ADDRESS M.D. Ft GG Meade, Md. — DATE SIGNED 30 Jan 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 2 Feb 55 — NAME OF CEMETERY OR CREMATORY Post Cemetery — LOCATION (City, town, or county) (State) Ft GG Meade, AA Co, Maryland

DATE REC'D BY LOCAL REGISTRAR 30 Jan 55 — REGISTRAR'S SIGNATURE ARTHUR J. GOMBOSH, CAPT., MSC

24. FUNERAL DIRECTOR CHAP. EUGENE DEVLIN — ADDRESS FT GG MEADE, MD.

2015R13361

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

MARYLAND 00110

00143
STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS
MARYLAND
LENGTH OF STAY (in this place)

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY AA.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Weems Creek

3. NAME OF DECEASED (Type or Print) (First) Gertrude (Middle) Agnes Ward (Last) Sindall
4. DATE OF DEATH (Month) (Day) (Year) 20 1955
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widow
8. DATE OF BIRTH 3-3-1886
9. AGE Last birthday 68 yrs.
If under 1 year: Months. Days
If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John T. Ward
14. MOTHER'S MAIDEN NAME Mariah Callindan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Jas. W. Sindall (2)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
420.1
Immediate cause (a) Acute Coronary Occlusion — Interval Between Onset and Death: Sudden
Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Cr. Myocarditis — Several yrs
(c) Attack of Congestive Failure — 1 Month

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 20, 1954, to Jan 20, 1955, that I last saw the deceased alive on Jan 20, 1955, and that death occurred at 11.45 P m., from the causes and on the date stated above.
SIGNATURE (Degree or title) J. Oliver Purves M.D. ADDRESS 40 Franklin St, Annapolis Md DATE SIGNED 1-21-55

23. BURIAL, CREMATION, REMOVAL (Specify) DATE 1-24-55 NAME OF CEMETERY OR CREMATORY St Mary's Cemetery LOCATION (City, town, or county) Baltimore (State) Md.

DATE REC'D BY LOCAL REG. Jan. 23, 1955
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

Item 21 Film G176 1-31-55 ams Item 14 FilmG176 1-31-55 et

Item 6 FilmG177-2-8-55 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00144

CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: COUNTY A A 00151 MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CHURCHTON, MD
LENGTH OF STAY (in this place) 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CHURCHTON
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) ELEANOR (Middle) KOLIPINSKI (Last) SMITH

4. DATE OF DEATH: (Month) JAN (Day) 22 (Year) 1955

5. SEX M/Female

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Divorced

8. DATE OF BIRTH: Oct 7 1905

9. AGE last birthday 49 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Mln.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: DR. Lewis Kolipinski

14. MOTHER'S MAIDEN NAME: Ella M. Soehngen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO

(If Yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Robert Andrew Smith, Churchton Md

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

916.0

IMMEDIATE CAUSE (A) Suffocation -

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Burns -

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) Home

21C. WHERE DID INJURY OCCUR? (City or town) Churchton (County) A.A. (State) Md.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) Jan 22 1955 6:30 PM.

21E. INJURY OCCURRED While at work ☐ Not while at work ☒

21F. HOW DID INJURY OCCUR? Apparently fell asleep with cigarette & ignited bed & house

22. I hereby certify that I attended the deceased from ..... , 19 .... , to 1-22 ..., 1955, that I last saw the deceased alive on Not at all , 19 ..., and that death occurred at 6:30 P.M., from the causes and on the date stated above.

SIGNATURE Emily H Wilson, M.D. M.D. ADDRESS Littleton, md. DATE SIGNED 1-22-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment

DATE THEREOF 1/25/55

NAME OF CEMETERY OR CREMATORY St Marys Cemetery

LOCATION (City, town, or county) (State) Washington D.C.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE Elsie Wentworth Williams

24. FUNERAL DIRECTOR Gilbert Pumphrey ADDRESS 5557 Wisconsin ave Bethesda Md

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00145

00152 **CERTIFICATE OF DEATH** Reg. Dist. No. 28

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Crownsville
LENGTH OF STAY (in this place) 5 yrs. 9 mos.
10 HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City 3V01.4
STREET ADDRESS (If rural give location) 205 Henrietta Street

3. NAME OF DECEASED: (Type or Print) (First) Holbert (Middle) (Last) Smith
4. DATE OF DEATH: (Month) 1 (Day) 19 (Year) 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Negro	Single	3/4/97?	57? yrs.	—	—	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10B. KIND OF BUSINESS OR INDUSTRY: - - - -
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: George Smith
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
Yes ✓	WWI	Unknown	Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

35 5 3

IMMEDIATE CAUSE (A) Epilepsy — INTERVAL BETWEEN ONSET AND DEATH: Known to us since

ANTECEDENT CAUSE (S) DUE TO 4/20/49

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Myocarditis — 3 mos

19A. DATE OF OPERATION: - - - - - 19B. MAJOR FINDINGS OF OPERATION - - - - - 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY - - - - - 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) - - - - - -

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY - - - - - M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR? - - - - - -

22. I hereby certify that I attended the deceased from 4/20 , 1949, to 1/19 , 1955, that I last saw the deceased alive on 1/19 , 1955, and that death occurred at 8:00 pM, from the causes and on the date stated above.

SIGNATURE (L. Benedict) M.D. ADDRESS Crownsville, Md. DATE SIGNED 1/19/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) DATE THEREOF 1/21/55 NAME OF CEMETERY OR CREMATORY Woodlawn LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR 1/21/55 REGISTRAR'S SIGNATURE Catherine M. Joyce, Deputy Registrar

24. FUNERAL DIRECTOR Wm. F. A. Hemsley ADDRESS 579 W. Baltimore

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

11-55

00146

MARYLAND 00153

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY: ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X GLEN BURNIE
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 210 4th Ave SE

2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie X
STREET ADDRESS (If rural, give location): 210 4th Ave. SE

3. NAME OF DECEASED (Type or Print): (First) IVAH (Middle) E (Last) SMITH

4. DATE OF DEATH (Month) (Day) (Year): JANUARY 24, 19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, (Specify): Widowed

8. DATE OF BIRTH: Aug. 22, 1880

9. AGE last birthday: 74 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Anne Arundel County, Md

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Robert Birckhead

14. MOTHER'S MAIDEN NAME: Jane Elower

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): --

16. SOCIAL SECURITY NO.: ----

17. INFORMANT AND ADDRESS: Miss Edith Smith -daughter- same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

410 X
Immediate cause (a) Mitral Insufficiency — Interval Between Onset and Death: 1 y.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalised arterioslerosis — ? .....

(c) Deformans Arthritis — 10 y.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No X ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from September 48 to 1/24/55 19..., that I last saw the deceased alive on 1/22/55., 19....., and that death occurred at 4 A.M. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Gustave K Rambert M.

ADDRESS: Glen Burnie

DATE SIGNED: 1/24/55

25. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: Jan. 26,55

NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery

LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: Jan 25 1955

REGISTRAR'S SIGNATURE: L. J. D'Alba

24. FUNERAL DIRECTOR: Ben L. Hopping and Son

ADDRESS: Annapolis, Maryland

MARYLAND 00111

00147

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY a a
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY a a
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 504 Sixth

3. NAME OF DECEASED (Type or Print) (First) Sarah (Middle) L. (Last) Smith
4. DATE OF DEATH (Month) 1 (Day) 4 (Year) 1955
5. SEX female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Or Divorced) Widowed
8. DATE OF BIRTH June 21-1871
9. AGE last birthday 83 yrs.
If under 1 year Months. Days
If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Shadyside Md.
12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME John R. Lee
14. MOTHER'S MAIDEN NAME Susan Crucesey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS John R. Smith (2)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4 to 0

Immediate cause (a) Chronic Myocarditis — Interval Between Onset and Death 2 wks.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Heart Disease — 17 yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 8, 1954 to Jan 4, 1955, that I last saw the deceased alive on Jan 4, 1955 and that death occurred at 10 A m., from the causes and on the date stated above.

SIGNATURE James A. Martin MD (Degree or title) ADDRESS Annapolis Md DATE SIGNED 1-6-55

23. BURIAL, CREMATION, REMOVAL (Specify) DATE 1-8-55 NAME OF CEMETERY OR CREMATORY Forest Lawn LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. January 8, 1955
REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR Wm. M. Duvall Sons ADDRESS Annapolis Md

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 1 3 1965
BUREAU V. S.

00112

MARYLAND

00148

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 1

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY A.A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS Annapolis Hosp. 63

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn
STREET ADDRESS (If rural, give location) 3918 6th Street

3. NAME OF DECEASED (Type or Print) (First) WILLIAM (Middle) P. (Last) SNYDER

4. DATE OF DEATH (Month) I/7 (Day) /55 (Year) 19

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M

8. DATE OF BIRTH I2/20/02

9. AGE Last birthday 52 yrs. If under 1 year Months. Days. If under 24 hrs. Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filling Station Prop.

10b. KIND OF BUSINESS OR INDUSTRY Own

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George

14. MOTHER'S MAIDEN NAME Annie Slaughter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Family - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Ruptured Aortic Aneurysm	2 days.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Dissecting Aneurysm of Aorta	6-8 mos.
	(c) Arteriosclerosis	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-6, 1955, to 1-7, 1955 that I last saw the deceased alive on 1-7, 1955 and that death occurred at 6:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Edward A Beck MD ADDRESS 41[illegible] Agate Ave, Annapolis DATE SIGNED 1-7-55

23. BURIAL, CREMATION, REMOVAL (Specify) B

DATE I/10/55

NAME OF CEMETERY OR CREMATORY Cedar Hill

LOCATION (City, town, or county) (State) Baltimore

DATE REC'D BY LOCAL REG. 1-10-55

REGISTRAR'S SIGNATURE A.W. Rodrue

24. FUNERAL DIRECTOR James L. McCully - I30 E. Fort Ave. ADDRESS

MARYLAND 00113

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 00149

1. PLACE OF DEATH
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 10 Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 51 USNH, Annapolis, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis 10
STREET ADDRESS (If rural, give location) 20 Southgate Avenue 1

3. NAME OF DECEASED (Type or Print): (First) Baby Boy (Middle) (Last) SOWELL

4. DATE OF DEATH: (Month) January (Day) 24 (Year) 1955

5. SEX: M

6. COLOR OR RACE: Cauc

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: 1-24-55

9. AGE last birthday: yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours 9 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard D Sowell

14. MOTHER'S MAIDEN NAME: Lois Irene Grimm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: -

17. INFORMANT AND ADDRESS: USNaval Hospital, Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

762.5
Immediate cause (a) Atelectasis — 762.5

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Prematurity with immaturity — 9 hrs
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-24, 1955, to 1-24-55, 1955 that I last saw the deceased alive on 1-24-, 1955, and that death occurred at 3:40 p.m., from the causes and on the date stated above.

SIGNATURE Earl R Stiles (Degree or title) LT MC ADDRESS US Naval Hospital DATE SIGNED 25 January 1955

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) DATE 1-26-55 NAME OF CEMETERY OR CREMATORY U.S. Naval Academy LOCATION (City, Twp, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Jan. 25, 1955 REGISTRAR'S SIGNATURE J. A. Dowell

24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

2015222291

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00150

00154

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Camp Parole — LENGTH OF STAY (in this place) 1 yr
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bristol
STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED: (Type or Print) (First) Ella (Middle) Estelle (Last) Stallings

4. DATE OF DEATH: (Month) Jan (Day) 30 (Year) 1955

5. SEX: female

6. COLOR OR RACE? white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: Sept 28, 1912

9. AGE last birthday: 2 1/2 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Calvert Co Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Wilmer Hall

14. MOTHER'S MAIDEN NAME: Pinky Fowler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Mrs Hazel Tucker, Camp Parole Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General-Metastasis to brain, Spine and Liver

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Carcinoma of the uterus

DUE TO

(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Dec 1953

19b. MAJOR FINDINGS OF OPERATION Carcinoma of the uterus

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/1/54, to 1/30/55, that I last saw the deceased alive on 1/30/55, and that death occurred at 6:02 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) Albert L. Anderson MD — ADDRESS Annapolis Md — DATE SIGNED 1/31/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Feb 7, 1955 — NAME OF CEMETERY OR CREMATORY Mt. Harmony Cem. — LOCATION (City, town, or county) (State) Mt. Harmony Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 1, 1955 — REGISTRAR'S SIGNATURE [illegible] — **24. FUNERAL DIRECTOR** Wm H. Hutchins, Owings, Md. — ADDRESS

VS. A15

00151

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00114 CERTIFICATE OF DEATH Reg. Dist. No. 21

1. PLACE OF DEATH.
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis.
LENGTH OF STAY (in this place) 2yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 20 Thompson St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis. 10
STREET ADDRESS (If rural give location) 20 Thompson St. 1

3. NAME OF DECEASED: (Type or Print) (First) Milton (Middle) (Last) Stiffler

4. DATE OF DEATH: (Month) Jan. (Day) 26, (Year) 1955.

5. SEX: Male 6. COLOR OR RACE: White 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed 8. DATE OF BIRTH: Febr. 14 1871 9. AGE last birthday 83. yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator Agent Penna. Railroad 10B. KIND OF BUSINESS OR INDUSTRY.

11. BIRTHPLACE (State or foreign country): Glen Rock, Pa. R.D. 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Mrs Whitney Harris, 20 Thompson St, Annapolis, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
177X
IMMEDIATE CAUSE (A) Carcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 1 year
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Osteosclerosis, generalized — unknown

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from , 19 ..., to 26 Jan 19 55 that I last saw the deceased alive on 26 Jan., 1955, and that death occurred at 4:15 PM, from the causes and on the date stated above.
SIGNATURE Edward L Beck. M. D. ADDRESS DATE SIGNED

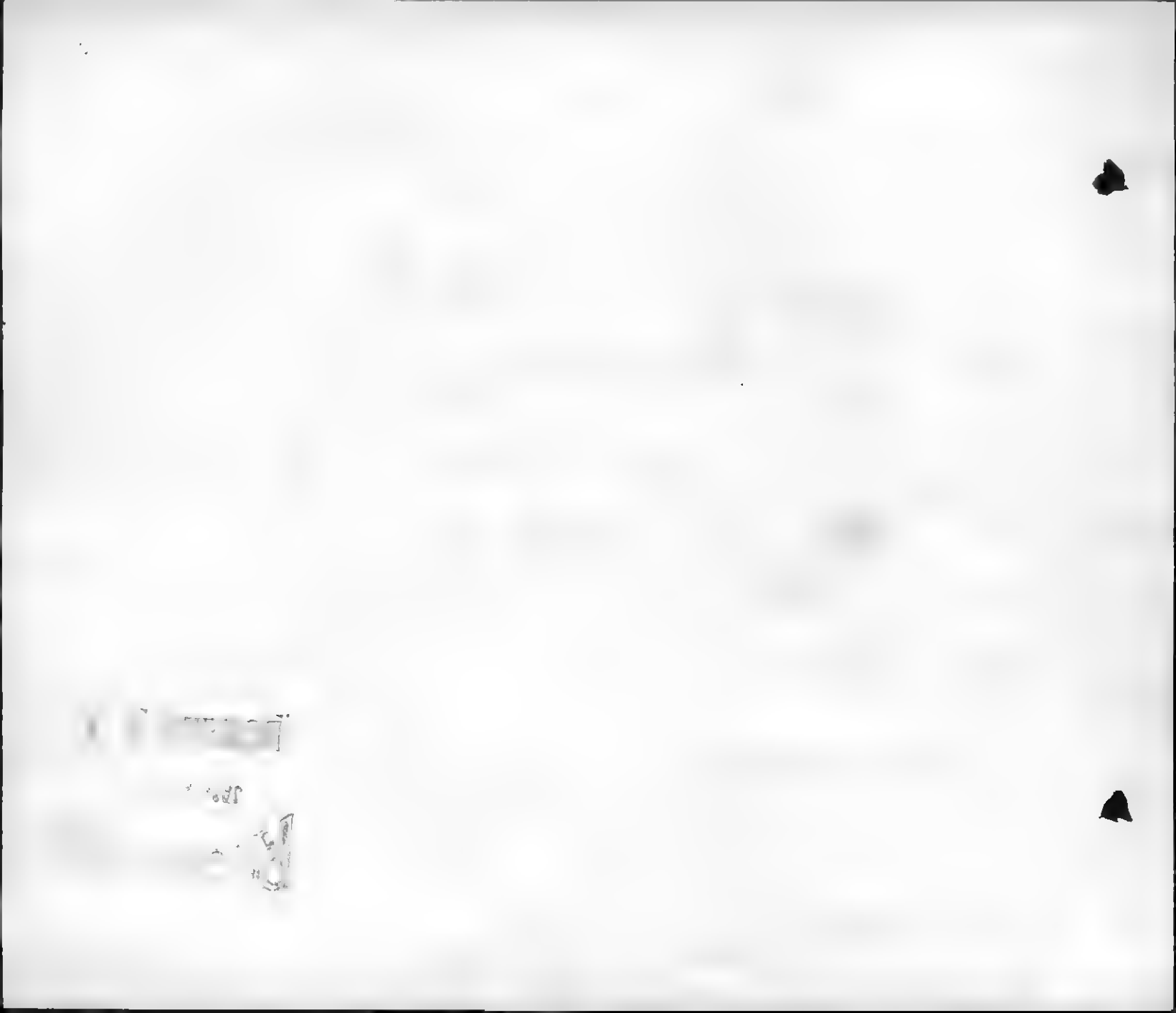
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF Jan. 30 1955 NAME OF CEMETERY OR CREMATORY New Freedom Cemetery LOCATION (City, town, or county) New Freedom, York Co. (State) Pa.

DATE REC'D BY LOCAL REGISTRAR Jan. 26, 1955 REGISTRAR'S SIGNATURE [illegible] 24. FUNERAL DIRECTOR Jacob Harlenstein ADDRESS New Freedom, Pa.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53



00152

MARYLAND 00115

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY A A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. General

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 70 East.

3. NAME OF DECEASED (Type or Print) (First) Clarence (Middle) Wilson (Last) Stryker

4. DATE OF DEATH (Month) 1 (Day) 1 (Year) 1955

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH 2-28-1863

9. AGE last birthday 91 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prof. St. John College Ret.

10b. KIND OF BUSINESS OR INDUSTRY Teaching

11. BIRTHPLACE (State or foreign country) Sharon Conn.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME John B Stryker

14. MOTHER'S MAIDEN NAME Annie Tibbits

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Adelaide B. Sturdevant 216 Prince Geo St Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive Heart Failure & Ac. Pulmonary Edema

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Calcified aortic Valve

(c)

INTERVAL BETWEEN ONSET AND DEATH: 12 hrs. / yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fracture of 7th left rib — 2 days

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..., 19..., to 1/1/, 1955, that I last saw the deceased alive on 1/1/, 1955, and that death occurred at 10:30 P. m., from the causes and on the date stated above.

SIGNATURE Frank M. Shilley (Degree or title) M.D. ADDRESS Annapolis DATE SIGNED 1/3/55

23. ~~BURIAL~~, CREMATION ~~REMOVAL~~ (Specify) DATE 1-4-55 NAME OF CEMETERY OR CREMATORY Ft Lincoln LOCATION (City, town, or county) Prince Geo Co (State) Md

DATE REC'D BY LOCAL REG. Jan. 3 1955 REGISTRAR'S SIGNATURE H. C. Arnold

24. FUNERAL DIRECTOR John M Layton Sons ADDRESS Annapolis Md

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 4 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00116

CERTIFICATE OF DEATH

Reg. Dist. No. 00153

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY A.A. MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis; LENGTH OF STAY (in this place) 10; HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis Md 10; STREET ADDRESS (If rural give location) 144 Prince George St.

3. NAME OF DECEASED: (Type or Print) (First) Louis (Middle) (Last) TARANTINO

4. DATE OF DEATH: (Month) 1 (Day) 30 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify):

8. DATE OF BIRTH: 4-1-1903

9. AGE last birthday 51 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE did not work

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Annapolis, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Pasquale Tarantino

14. MOTHER'S MAIDEN NAME: Flora Pennino

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Henry J. Tarantino Annapolis Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

465X

IMMEDIATE CAUSE (A) Massive pulmonary emboli bilateral — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr.

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerotic cardiovascular disease (Non-Contributory) — 10 yrs.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/10 ..., 1955, to ... 1/30 ..., 1955, that I last saw the deceased alive on ... 1/30 ..., 1955, and that death occurred at 11:30 AM, from the causes and on the date stated above.

SIGNATURE J Borromeo M. D. ADDRESS Annapolis MD DATE SIGNED 1/31/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 2/1/55 — NAME OF CEMETERY OR CREMATORY St. Mary's — LOCATION (City, town, or county) (State) Annapolis Md

DATE REC'D BY LOCAL REGISTRAR Jan. 31, 1955 — REGISTRAR'S SIGNATURE H. C. Dorsch

24. FUNERAL DIRECTOR John M. Taylor & Sons — ADDRESS Annapolis

BUREAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00154

00155 **CERTIFICATE OF DEATH** Reg. Dist. No. 23

1. PLACE OF DEATH:
COUNTY Balto. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville
LENGTH OF STAY (in this place) 14 days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 900 Broadview Blvd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville
STREET ADDRESS (If rural give location) 900 BROADVIEW BLVD.

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) Newton (Last) Thrale

4. DATE OF DEATH: (Month) Jan (Day) 19 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widower

8. DATE OF BIRTH. Oct. 1 1881

9. AGE last birthday 69 yrs | IF UNDER 1 YEAR: Months Days | IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Produce

10B. KIND OF BUSINESS OR INDUSTRY. Dairy

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Chas. Frank Thrale

14. MOTHER'S MAIDEN NAME: Kattie Rush

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Irma Stewart (daughter)

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

14 X

IMMEDIATE CAUSE

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(A) Cancer of Throat (Oesophagus) DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs -

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: Feb. 1953

19B. MAJOR FINDINGS OF OPERATION Cancer -

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 16, 1955, to Jan 19, 1955, that I last saw the deceased alive on Jan. 19, 1955, and that death occurred at 7 P. M, from the causes and on the date stated above.

SIGNATURE Chas. L. Ball Jr. M. D. ADDRESS Lutherville DATE SIGNED Jan 19 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Jan 22/55 | NAME OF CEMETERY OR CREMATORY Loudon Pk | LOCATION (City, town, or county) (State) Balto. Md

DATE REC'D BY LOCAL REGISTRAR 1-21-55 | REGISTRAR'S SIGNATURE R W Hedrick | 24 FUNERAL DIRECTOR. ADDRESS Harry H. Witte 4101 Edmondson ave.

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14.5.24
69
8 5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00155

CERTIFICATE OF DEATH

Reg. Dist. No. 78

00156

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Crownsville
LENGTH OF STAY (in this place) 9 mos. 2 days
10 HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 1044 N. Eden Street

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) Levi (Last) Tucker

4. DATE OF DEATH: (Month) 1 (Day) 10 (Year) 1955

5. SEX: Male | 6. COLOR OR RACE: Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married | 8. DATE OF BIRTH: 6/20/87 | 9. AGE last birthday 67 yrs. | IF UNDER 1 YEAR Months — Days — | IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer | 10B KIND OF BUSINESS OR INDUSTRY: Unknown | 11. BIRTHPLACE (State or foreign country): Maryland | 12 CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown | 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. | (If Yes, give war or dates of service) Unk. | 16. SOCIAL SECURITY NO. Unknown | 17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Bronchopneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSE (S) DUE TO (B) Myocardial degeneration with hemorrhages — 3 years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Generalized arteriosclerosis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile arteriosclerotic, psychosis

19A. DATE OF OPERATION: — | 19B. MAJOR FINDINGS OF OPERATION — | 20. AUTOPSY? YES X NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) —

21D TIME OF INJURY (Month) (Day) (Year) (Hour) — M. | 21E INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 1/5, 1955 to 1/10, 1955 that I last saw the deceased alive on 1/10, 1955, and that death occurred at 1:30p.M, from the causes and on the date stated above.

SIGNATURE Hildegard Heard Reissmann M. D. | ADDRESS Crownsville, Md. | DATE SIGNED 1/11/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | DATE THEREOF 1-14-55 | NAME OF CEMETERY OR CREMATORY BASIL CHAPEL | LOCATION (City, town, or county) (State) Rockyville Md

DATE REC'D BY LOCAL REGISTRAR 1-13-55 | REGISTRAR'S SIGNATURE [illegible] | FUNERAL DIRECTOR Joseph B. Lock. Jr. | ADDRESS 1304 N. Central Ave

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00156

00157 CERTIFICATE OF DEATH

Reg. Dist. No. ...

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Route #1-Box 114A Glen Burnie P.O. LENGTH OF STAY (in this place) 15 Yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 1

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Route #1 Box 114A, Glen Burnie P.O.
STREET ADDRESS (If rural give location) X

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Jacob (Last) WAGNER
4. DATE OF DEATH: (Month) Jan. (Day) 12 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday: yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
MALE	White	MARRIED	Feb 2, 1889	65				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
OPERATING ENGINEER	CONSTRUCTION	Poland	U.S.A.

13. FATHER'S NAME: ZAWADZKI
14. MOTHER'S MAIDEN NAME: BUJARSKA

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
NO	—	213-03-0610	FRANCES A. WAGNER - WIFE SAME

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
Immediate cause	(a) Generalized Carcinomatosis	6 mos
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO Carcinoma, Lung, Rt.	1 yr
	(c) DUE TO Respiratory Failure	2 hrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. M/Nutrition

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
December 22'54	Carcinoma, Lungs, Pleura, Trachea & Mediastinum	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/27, 1954 to 1/12, 1955, that I last saw the deceased alive on 1/12, 1955, and that death occurred at 5:30 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
P.W. Richard M.D. 715 Colter Rd Glen Burnie Md 1/12/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town or county) (State)
BURIAL	1/17/55	HOLY CROSS	RITCHIE HWY - BALTO. MD.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
1/14/55	[signature]	JOHN F. DENNY, INC. 715 LIGHT ST - 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00158

CERTIFICATE OF DEATH

00157

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Riviera Beach
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Riviera Beach
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED: (First) EARL (Middle) SMITH (Last) WATSON

4. DATE OF DEATH: (Month) January (Day) 11, (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Legal Sep.

8. DATE OF BIRTH: Apr. 23, 1880

9. AGE last birthday: 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Ret. Railway Mail Clerk

10b. KIND OF BUSINESS OR INDUSTRY: U. S. P. O.

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Thomas Watson

14. MOTHER'S MAIDEN NAME: Mary Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes — (If Yes, give war or dates of service) SAW

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Mrs. Agnes S. Holler, Riviera Beach, Maryland

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause: 420.1 (a) Coronary Thrombosis — 30 minutes

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Arteriosclerotic Cardio-vascular disease

DUE TO (c) with Congestive Heart Failure — 2 years

11. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death: Generalized rheumatoid arthritis — 3 years

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 12, 1950, to January 11, 1955, that I last saw the deceased alive on January 11, 1955, and that death occurred at 3:45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Keith M. McLaughlin, M.D. — ADDRESS: Pasadena, Md. — DATE SIGNED: January 11, 1955

23. BURIAL, CREMATION, REMOVAL, (Specify): cremation — DATE THEREOF: 1/13/55 — NAME OF CEMETERY OR CREMATORY: Green Mount Crematory — LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR: 1-12-55 — REGISTRAR'S SIGNATURE: C W Hedrick — 24. FUNERAL DIRECTOR: Wm. Cook, Inc., — ADDRESS: 1217 St. Paul Street

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00159 CERTIFICATE OF DEATH

Reg. Dist. No. 00158

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Crownsville; LENGTH OF STAY (In this place) 10yrs. 7½ months; HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore City; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1407 Harford Avenue; STREET ADDRESS (If rural give location) Baltimore City

3. NAME OF DECEASED: (Type or Print) (First) Frank (Middle) (Last) Watson

4. DATE OF DEATH. (Month) 1 (Day) 2 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 1893?

9. AGE last birthday 61? yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Ordrie Watson

14. MOTHER'S MAIDEN NAME: Annie McLaurin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) General Paresis — Known to us since 5/26/44

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: - - - - - -

19B. MAJOR FINDINGS OF OPERATION -

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) - - - - - - - - - - - - - - - - - -

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) - - - - - - - - - - - - - - - - - -

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? - - - - - - - - - - - - - - - - - -

22. I hereby certify that I attended the deceased from 1/ 21 , 1948 to 1/2 , 1955, that I last saw the deceased alive on 1/2 , 1955, and that death occurred at ... M, from the causes and on the date stated above.

SIGNATURE L. benedict, M.D. ADDRESS Crownsville, Md. DATE SIGNED 1/2/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF 1-4 55 | NAME OF CEMETERY OR CREMATORY Crownsville State Hospital | LOCATION (City, town, or county) (State) Crownsville Md.

DATE REC'D BY LOCAL REGISTRAR 1-15-55 | REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR Arnold N. Eichert, M.D. ADDRESS Crownsville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00159

00160 CERTIFICATE OF DEATH Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater, P.O.
LENGTH OF STAY (in this place) 9 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route # 1 Box# 393 Shoreham Beach

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Pr. Geo.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN College Park 16 X-2
STREET ADDRESS (If rural give location) Anne Arundel Hall University of Maryland

3. NAME OF DECEASED: (Type or Print) (First) ALTA (Middle) WEDEMAN (Last) WHITE

4. DATE OF DEATH: (Month) (Day) (Year) January 14th 19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: Sept. 24th, 1893

9. AGE last birthday: 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Supervisor of Residence Hall

10b. KIND OF BUSINESS OR INDUSTRY: Univ. of Md.

11. BIRTHPLACE (State or foreign country): Uniondale, Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George F. Wedeman

14. MOTHER'S MAIDEN NAME: Ellen Antoinette Pierce

15 WAS DECEASED EVER IN U S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) None

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Mrs. Della E. Millard, Shoreham Beach, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

17-X

Immediate cause (a) Cerebral thrombosis DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerosis DUE TO

(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 9, 1954, to Jan. 4, 1955, that I last saw the deceased alive on Jan. 14, 1955, and that death occurred at 11:30 AM from the causes and on the date stated above.

SIGNATURE (Degree or title) Emily H. Wilson, M.D. ADDRESS Cottican, Md. DATE SIGNED 1-16-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Jan. 17/1955 NAME OF CEMETERY OR CREMATORY St. John's Church Cem. LOCATION (City, town, or county) Beltsville, Pr. Geo., Md. (State)

DATE REC'D BY LOCAL REGISTRAR 1/17/55 REGISTRAR'S SIGNATURE Amanda Downey Edward Collinson

24. FUNERAL DIRECTOR W. W. Chambers Company, Riverdale, Md. ADDRESS

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00161

CERTIFICATE OF DEATH

00160

Reg. Dist. No. [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 PLACE OF DEATH:
COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN X GLEN BURNIE
LENGTH OF STAY (in this place) 3 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Plaza Manor Nursing Home Box 376-A; Rt 2, Glen Burnie

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Balto. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore city 3 Yrs 1-4
STREET ADDRESS (If rural give location) 1016 W. Lanvale St

3 NAME OF DECEASED: (Type or Print) (First) SYLVIA (Middle) (Last) WILSON

4. DATE OF DEATH: (Month) JAN. (Day) 19 (Year) 1955

5. SEX: F

6. COLOR OR RACE: Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Wid.

8. DATE OF BIRTH: Feb 12, 1875

9. AGE last birthday: 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife.

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME: Thomas Grier

14. MOTHER'S MAIDEN NAME: Mary Brown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) [illegible] (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Mrs Maggie Patton (daughter) 1016 W. Lanvale St Balto., Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 420.0 (a) Arteriosclerotic heart disease — Interval Between Onset And Death: 10 yrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 10 yrs
DUE TO (c) Senility

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) no

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) none m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... 19..., to 1-19..., 1955, ~~that I last saw the deceased alive on ..... 19 ..., and~~ that death occurred at 10:45 A.M., from the causes and on the date stated above.

SIGNATURE H.F. Manuzak (Degree or title) M.D. ADDRESS 901 Edgerly Rd, Glen Burnie, Md DATE SIGNED 1-19-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 1/22/55

NAME OF CEMETERY OR CREMATORY Family Lot

LOCATION (City, town, or county) (State) Gt. K. & Queens

DATE REC'D BY LOCAL REGISTRAR 1-20-55

REGISTRAR'S SIGNATURE A W [illegible]

24. FUNERAL DIRECTOR Earl Gilmore ADDRESS 519 Mosher St.

Note: This patient was under the constant care of Dr. Jos. Talbot & Dr. H. Pantert, of Glen Burnie. I was called when they were not available.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00161

00162

CERTIFICATE OF DEATH

Reg. Dist. No. 17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Mayo
LENGTH OF STAY (in this place) Life.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 —

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Aa.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo
STREET ADDRESS (If rural give location) X 1

3. NAME OF DECEASED: (Type or Print) (First) Edith (Middle) Estelle (Last) Wright
4. DATE OF DEATH: (Month) (Day) (Year) Jan 20 – 1955

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Aug 3 – 1881
9. AGE Last birthday: 73 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel O Compton
14. MOTHER'S MAIDEN NAME: Anna Caroline Platt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No: —
17. INFORMANT & ADDRESS: R Oliver Wright Mayo Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) Coronary occlusion — Interval Between Onset And Death: 1/2 hr

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — (b) Arteriosclerotic cardiovascular disease

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 10 ,19 54 , to Jan 20 , 19 55 , that I last saw the deceased alive on Jan 19, 19 55, and that death occurred at 5:20 pm , from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

R Bowers Wm O — Mayo Forest Rec. — Amended 1/20/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Jan 24-1955 — NAME OF CEMETERY OR CREMATORY: Mt Olive — LOCATION (City, town, or county) (State): Randallstown Md

DATE REC'D BY LOCAL REGISTRAR: 1-21-55 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR: Bertram Yost — ADDRESS: 2224 Eutaw St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00162

00163 **CERTIFICATE OF DEATH** Reg. Dist. No. 28

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Crownsville
LENGTH OF STAY (in this place) 14 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn X
STREET ADDRESS (If rural give location) 1 Queenstown Section

3. NAME OF DECEASED: (Type or Print) (First) GEORGE (Middle) (Last) YOUNG

4. DATE OF DEATH: (Month) 1 - (Day) 11 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 9/12/77

9. AGE last birthday: 77 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10B. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: George Dennis Young

14. MOTHER'S MAIDEN NAME: Harriett Elizabeth Boens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS. Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 422.1

(A) Chronic Myocardial Disease — INTERVAL BETWEEN ONSET AND DEATH: Known to us since 12/28/54

ANTECEDENT CAUSE (S)

DUE TO

(B) Generalized Arteriosclerosis — " — "

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Brain Syndrome

19A. DATE OF OPERATION: — — — — —

19B. MAJOR FINDINGS OF OPERATION — — — — — — — — — — — — — — —

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — — — — —

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) — — — — — — — — —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — — M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? — — — — — — — — —

22. I hereby certify that I attended the deceased from 12/28, 1954, to 1/11, 1955 that I last saw the deceased alive on 1/11, 1955, and that death occurred at 10:05 P.M., from the causes and on the date stated above.

SIGNATURE Guilford E. Naranjit M.D. ADDRESS Crownsville, Md. DATE SIGNED 1/11/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF 1-20-55 | NAME OF CEMETERY OR CREMATORY Mt Auburn | LOCATION (City, town, or county) (State) md

DATE REC'D BY LOCAL REGISTRAR 1-19-55 | REGISTRAR'S SIGNATURE A W Hedrick | 24. FUNERAL DIRECTOR Geo. A. Kelson | ADDRESS 1303 Presstman st

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND 00117

STATE DEPARTMENT OF HEALTH

00163

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General Hospital 63

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: nr Annapolis
STREET ADDRESS (If rural, give location): Pendenis Mount X

3. NAME OF DECEASED (Type or Print): (First) CATHERINE (Middle) ZINDORF (Last)

4. DATE OF DEATH: (Month) JANUARY (Day) 14 (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: March 3 1869

9. AGE last birthday: 85 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Deaton, Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Herman Angelbeck

14. MOTHER'S MAIDEN NAME: Louise Seitz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): none
(If year, give war or dates of service): none

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mrs Catherine Carrick- daughter- same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

904.0
Immediate cause (a) Cardiac failure — 7

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Pneumonia — 10 days

(c) Fracture, left, at intertrochanteric 31 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Aged - many marked senile changes

19a. DATE OF OPERATION: 12-9-1954

19b. MAJOR FINDINGS OF OPERATION: Intertrochanteric fracture

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Annapolis (CITY OR TOWN) Anne Arundel (COUNTY) Md (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): 12 9 1954 11 a.m.

INJURY OCCURRED While at Work ☐ Not While At work ☑

HOW DID INJURY OCCUR? Jumping - fell in her home

22. I hereby certify that I attended the deceased from Dec 9, 1954, to Jan 14, 1955, that I last saw the deceased alive on Dec 13, 1955, and that death occurred at 4:08 P.m., from the causes and on the date stated above.

SIGNATURE: Harold A. Kahlman M.D. (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 1-17-55 1955 — NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery — LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: Jan. 17, 1955 — REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR: Ben L. Hopping and Son — ADDRESS: Annapolis, Md.

RECEIVED
JAN 19 19[illegible]
BUREAU V. S.

MARYLAND

Zurgable

00118

CERTIFICATE OF DEATH

STATE DEPARTMETT OF HEALTH

00164

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis md
LENGTH OF STAY (in this place) 2 wks
10 63 HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis md
10 1
STREET ADDRESS (If rural, give location) 49 Spa Rd

3. NAME OF DECEASED (Type or Print): (First) John (Middle) W. (Last) Zurgable

4. DATE OF DEATH: (Month) Jan (Day) 15 (Year) 19 55

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: April 25 1868

9. AGE last birthday: 86 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Packer

10b. KIND OF BUSINESS OR INDUSTRY: Hochschild-Kohn-Co

11. BIRTHPLACE (State or foreign country): Frederick Co md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs Geo. A. Janzen 4005 Glenmore Ave

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

451X

Immediate cause (a) Ruptured Aneurysm Abdominal Aorta — Interval Between Onset and Death: 1-2 yrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis, generalized — unknown.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1954, to Jan 15, 1955, that I last saw the deceased alive on Jan 15, 1955 and that death occurred at 11:45 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Edward A Beck md ADDRESS 4 Southgate Ave Annapolis DATE SIGNED 1-15-55

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: 1/18/55

NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem

LOCATION (City, town, or county) (State): Balto md

DATE REC'D BY LOCAL REG. 1-19-55

REGISTRAR'S SIGNATURE A W Redgrave

24. FUNERAL DIRECTOR: Lansdale Funeral Home ADDRESS 7401 Belair Rd

1